

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

5227

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

05218

Reg. Dist. No. 23

1. PLACE OF DEATH: COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Luthieum</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
TOWN <u>Luthieum</u> LENGTH OF STAY (In this place) <u>6 days</u>		TOWN <u>Baltimore</u> 3401.4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Snyder Trade Camp - Hammond Ferry Rd</u>		STREET ADDRESS (If rural, give location) <u>109 - N. Patterson Park</u>	
3. NAME OF DECEASED (First) <u>Ronald</u> (Middle) <u>Dean</u> (Last) <u>Adams</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>20</u> (Year) <u>1955</u>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>W.</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH <u>12/28/54</u> 9. AGE last birthday <u>5</u> yrs. If under 1 year: Months <u>3</u> Days <u>27</u> If under 24 hrs. Mfs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ralford Adams</u>		14. MOTHER'S MAIDEN NAME <u>Christine Dean</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Mrs. H. Adams, (parents)</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
924.0 Immediate cause (a) <u>Asphyxiation - caused by head being caught between - wooden sail of bed and mattress.</u>			<u>Sudden</u>
Antecedent cause(s) (b) <u>None</u>			
2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) <u>Home</u> (CITY OR TOWN) <u>Luthieum</u> (COUNTY) <u>P. A.</u> (STATE) <u>Md</u>	
TIME (Month) (Day) (Year) (Hour) <u>6/20/55 12:30 p.m.</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> HOW DID INJURY OCCUR? <u>Head caught between bed rail and mattress</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>Kustans H. Parker M.D.</u> (Degree or title)		ADDRESS <u>Glen Burnie, Md</u> DATE SIGNED <u>6/20/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>June 22, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		LOCATION (City, town, or county) <u>Glen Burnie, Maryland</u> (State)	
DATE REC'D BY LOCAL REG. <u>June 21, 1955</u>		REGISTRAR'S SIGNATURE <u>Calwell Woodruff</u>	
24. FUNERAL DIRECTOR <u>R. V. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>	

1VV499V99V L. J. O'Leary

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JUN 24 1955

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** No. 27

Reg. Dist.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Anne Arundel</b>	MARYLAND	STATE <b>Maryland</b> COUNTY <b>Anne Arundel</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>X TOWN Camp Meade</b>	LENGTH OF STAY (in this place) <b>2hrs</b>	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <b>Annapolis,</b>	<b>10</b>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>DOA Fort Meade Hospital</b>		STREET ADDRESS (If rural, give location) <b>1115 Monroe Street</b>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <b>WILLIAM</b>	(Middle) <b>S</b>	(Last) <b>AISSQUITH</b>	(Month) <b>JUNE</b> (Day) <b>27</b> (Year) <b>19 55</b>
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH: <b>Dec. 24, 1927</b>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY: <b>Bldg. Construction</b>	9. AGE last birthday: <b>27</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (State or foreign country): <b>Riva, Anne Arundel, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME: <b>Raymond Aisquith</b>		14. MOTHER'S MAIDEN NAME: <b>Elizabeth Davis</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>Yes</b> (If Yes, give war or dates of service) <b>WW II</b>		16. SOCIAL SECURITY No.: <b>217 24 606</b>	
17. INFORMANT & ADDRESS: <b>Helen V. Aisquith- Wife- same as # 2</b>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
<b>902.3</b> Immediate cause (a) <b>Fractured skull (Intracranial injury)</b> DUE TO Antecedent cause(s) (b) _____ Diseases or conditions, if any, giving rise to the above cause DUE TO _____ stating underlying cause last (c) _____			<b>Sudden</b>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: <b>June 27, 55</b>		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, street, office bldg., etc.) <b>Camp Meade</b>	21c. (City or town) <b>Anne Arundel</b>	(County) <b>Maryland</b>
21d. TIME (Month) (Day) (Year) (Hour) <b>June 27, 55 A.M.</b>	21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>Fell from roof of Bldg, under construction</b>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <b>Donald K. Paulsen, M.D., Deputy Medical Examiner</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>June 27, 1955</b>	
23. BURIAL, CREMATION, REMOVAL (Specify): <b>Burial</b>		DATE THEREOF <b>June 30, 55</b>	
NAME OF CEMETERY OR CREMATORY <b>Hillcrest Memorial Cem.</b>		LOCATION (City, town, or county) (State) <b>Annapolis, Maryland</b>	
DATE REC'D BY LOCAL REG. <b>June 29, 1955</b>		REGISTRAR'S SIGNATURE <b>Wm. Taylor</b>	
24. FUNERAL DIRECTOR <b>Hopping Funeral Home</b>		ADDRESS <b>Annapolis, Md.</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED JUL 5 1955

JUL 5 1955

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JUL 5 1955

BUREAU V. S.

MARYLAND

5229

STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH- COUNTY <u>Anne Arundel L.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD.</u> COUNTY <u>Anne Arundel</u>	
X CITY (If outside corporate limits, write RURAL and give nearest town) TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>OLD County RD Mr. Jones</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>OLD County RD</u> <u>Near Jones Station</u>		STREET ADDRESS (If rural, give location) <u>Rural.</u>	
3. NAME OF DECEASED (Type or Print) <u>CAROLINE. Ellen AYERS.</u>		4. DATE OF DEATH <u>June. 13. 1955.</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>Jan 25, 1872</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rtd-Head Private School</u>		9. AGE last birthday <u>83</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Portland Maine.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Josiah ELDER</u>		14. MOTHER'S MAIDEN NAME <u>Rose Snow.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give year or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Daughter. Mrs. J.S. Pennington.</u>		18. MEDICAL CERTIFICATION	

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Pulmonary Edema.

INTERVAL BETWEEN ONSET AND DEATH

1 hr.

Antecedent cause(s)

(b) Coronary thrombosis.

(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

Generalized Arteriosclerosis.II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from June, 1955 to June 13 1955, that I last saw the deceasedalive on June 13, 1955, and that death occurred at 0430 A. m., from the causes and on the date stated above.SIGNATURE Robert G. Hahn. M.D. Severna Park Md DATE SIGNED 13 June 55

23. BURIAL, CREMATION REMOVAL (Specify) <u>Removal</u>	DATE <u>6/14/55</u>	NAME OF CEMETERY OR CREMATORY <u>Ft. Hill Burial Park</u>	LOCATION (City, town, or county) <u>Lynchburg, Va.</u>	(State)
DATE REC'D BY LOCAL REG. <u>JUN 20 1955</u>	REGISTRAR'S SIGNATURE <u>Huntington Williams</u>	24. FUNERAL DIRECTOR <u>Wm. J. Vickner &amp; Sons</u>	ADDRESS <u>Balto 17 Md</u>	

BUREAU V. B.

JUN 24 1955

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5230

## CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundel</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>			
TOWN <u>Glen Burnie</u> LENGTH OF STAY (in this place) <u>15 yrs</u>				TOWN <u>Glen Burnie</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>207 Kent Rd (N.E.)</u>				STREET ADDRESS (If rural give location) <u>207 Kent Rd (NE)</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Benjamin Franklin BAHNLEIN</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>June 30 1955</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Mar.</u>		8. DATE OF BIRTH: <u>7 June 1885</u>	
9. AGE last birthday: <u>70</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.		11. BIRTHPLACE (State or foreign country): <u>Balto, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Yes - USA</u>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Stock Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Amer. Can Co.</u>			
13. FATHER'S NAME: <u>Albert Bahnlein</u>				14. MOTHER'S MAIDEN NAME: <u>not known</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>				16. SOCIAL SECURITY No.: <u>212-03-8908</u>		17. INFORMANT & ADDRESS: <u>207 Kent Rd</u>	
				18. MEDICAL CERTIFICATION			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				Interval Between Onset And Death	
181X Immediate cause (a) <u>acute uremia</u>				<u>2 days</u>	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Generalized metastases</u>				<u>3 mos.</u>	
(c) <u>Carcinoma of bladder</u>				<u>1 yr.</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Generalized arthritis</u>				<u>3 yrs</u>	
19a. DATE OF OPERATION: <u>26 April 1955</u>		19b. MAJOR FINDINGS OF OPERATION: <u>Cystoscopy - carcinoma of bladder</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>NO</u>		PLACE (Home, farm, factory, street, office bldg., etc.) <u>OF INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from ..... 19....., to 30 June....., 1955, that I last saw the deceased alive on ..... 19....., and that death occurred at 2 P.M. from the causes and on the date stated above. SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>July 4, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Landon Park Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore - Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>July 2, 1955</u>		REGISTRAR'S SIGNATURE <u>L. J. DeAlba</u>		24. FUNERAL DIRECTOR <u>A. H. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>	

Note: This is a pt. of Dr. Abr. Tankin of Balto, Md. for several months & 2 weeks called to pronounce the pt. dead when Dr. Tankin was not available.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 51

JUL 6 1955

RECEIVED



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**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5231

CERTIFICATE OF DEATH

05222

Reg. Dist. No. 242

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <u>Prince George's</u> <b>MARYLAND</b>		STATE <u>MARYLAND</u> COUNTY <u>ARUNDEL</u>	
CITY (if outside corporate limits, write RURAL OR end give nearest town) <u>GLEN BURNIE</u>		CITY (if outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u>	
TOWN <u>PLAZA MANOR CONVALES</u>		TOWN <u>GLEN BURNIE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>CENT HOME Route 2 Box 3764</u>		STREET ADDRESS (If rural give location) <u>Route 2 Box 3764</u>	
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <u>KATHLEEN N. BARTLEY</u>		<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>June 28 1955</u>	
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>	<b>8. DATE OF BIRTH</b> <u>Oct 23, 1868</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	<b>11. BIRTHPLACE</b> (State or foreign country) <u>Makin Georgia</u>
<b>13. FATHER'S NAME</b> <u>Abraham Newman</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Margaret Hughes</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>none</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If Yes, give war or dates of service)		<b>17. INFORMANT &amp; ADDRESS</b> <u>Julian C. Bartley, 233 Constitution Ave. N.E. Wash. D.C.</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>		<b>18. MEDICAL CERTIFICATION</b>	
<b>420.0 IMMEDIATE CAUSE</b> (A) <u>ARTERIOSCLEROTIC HEART DISEASE</u>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>ANTECEDENT CAUSE(S)</b> DUE TO <u>PAROTITIS, acute, rt.</u>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b> DUE TO			
<b>STATING UNDERLYING CAUSE LAST.</b> DUE TO			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>			
<b>19a. DATE OF OPERATION</b> <u>0</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>	
<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>		<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>	
<b>21e. INJURY OCCURRED While at work Not while at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>	
<b>22. I hereby certify that I attended the deceased from May 3, 1955, to June 28, 1955, that I last saw the deceased alive on June 20, 1955, and that death occurred at 8:05 P.M. from the causes and on the date stated above. 6/28/55</b>			
<b>SIGNATURE</b> <u>Joseph T. ...</u>		<b>ADDRESS (Street, city, town, state)</b> <u>102 Baltimore-Annapolis Blvd. Glen Burnie, Md.</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>BURIAL</u>		<b>DATE THEREOF</b> <u>7-1-1955</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>	
<b>DATE</b> <u>6-30-55</u>		<b>ADDRESS</b> <u>W.W. Chambers &amp; Co Washington, D.C.</u>	

# CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF CORONER

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF DECEASED

13. SIGNATURE OF BURIAL

14. SIGNATURE OF INTERMENT

15. SIGNATURE OF CREMATION

16. SIGNATURE OF OTHER

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60. SIGNATURE OF

BUREAU V. E.

JUL 5 1955

RECEIVED

5232

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

COUNTY Anne Arundel MARYLAND  
 CITY (If outside corporate limits, write RURAL and give nearest town) Brooklyn LENGTH OF STAY (in this place) 10 yrs  
 OR TOWN Rural  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 5317 Ritchie Hgwy.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY A.A.  
 CITY (If outside corporate limits, write RURAL and give nearest town) Brooklyn  
 OR TOWN Rural  
 STREET ADDRESS (If rural give location) 5317 Ritchie Hgwy

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

Cecilia—Beltz

## 4. DATE OF DEATH:

(Month)

(Day)

(Year)

June

30

1955

## 5. SEX:

F

## 6. COLOR OR RACE:

W

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

Married

## 8. DATE OF BIRTH:

Nov. 18 1896

## 9. AGE last birthday:

58 yrs.

Months

Days

Hours

Min.

## 10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):

Housewife

## 10b. KIND OF BUSINESS OR INDUSTRY:

None

## 11. BIRTHPLACE (State or foreign country):

KANSAS

## 12. CITIZEN OF WHAT COUNTRY?

U.S.

## 13. FATHER'S NAME:

Martin Briskey

## 14. MOTHER'S MAIDEN NAME:

UNKNOWN

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)

No

## 16. SOCIAL SECURITY No.:

None

## 17. INFORMANT &amp; ADDRESS:

Paul D. Beltz 5317 Ritchie Hgwy

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.2  
 Immediate cause

(a)

DUE TO

cardiac insufficiency

## Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

anular plaque - myocardial damage

(c)

Interval Between Onset And Death

7-19-546-30-55

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY ?

Yes ☐ No ☒

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)  
 OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
 OF INJURY

m.

INJURY OCCURRED  
 While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from 7-19-54 to 6-30-55, that I last saw the deceased

alive on 6-24-55, 1955, and that death occurred at 6-30-55, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Rugan Schaefer M.D.3904 S. Howard 7-1-58

## 23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

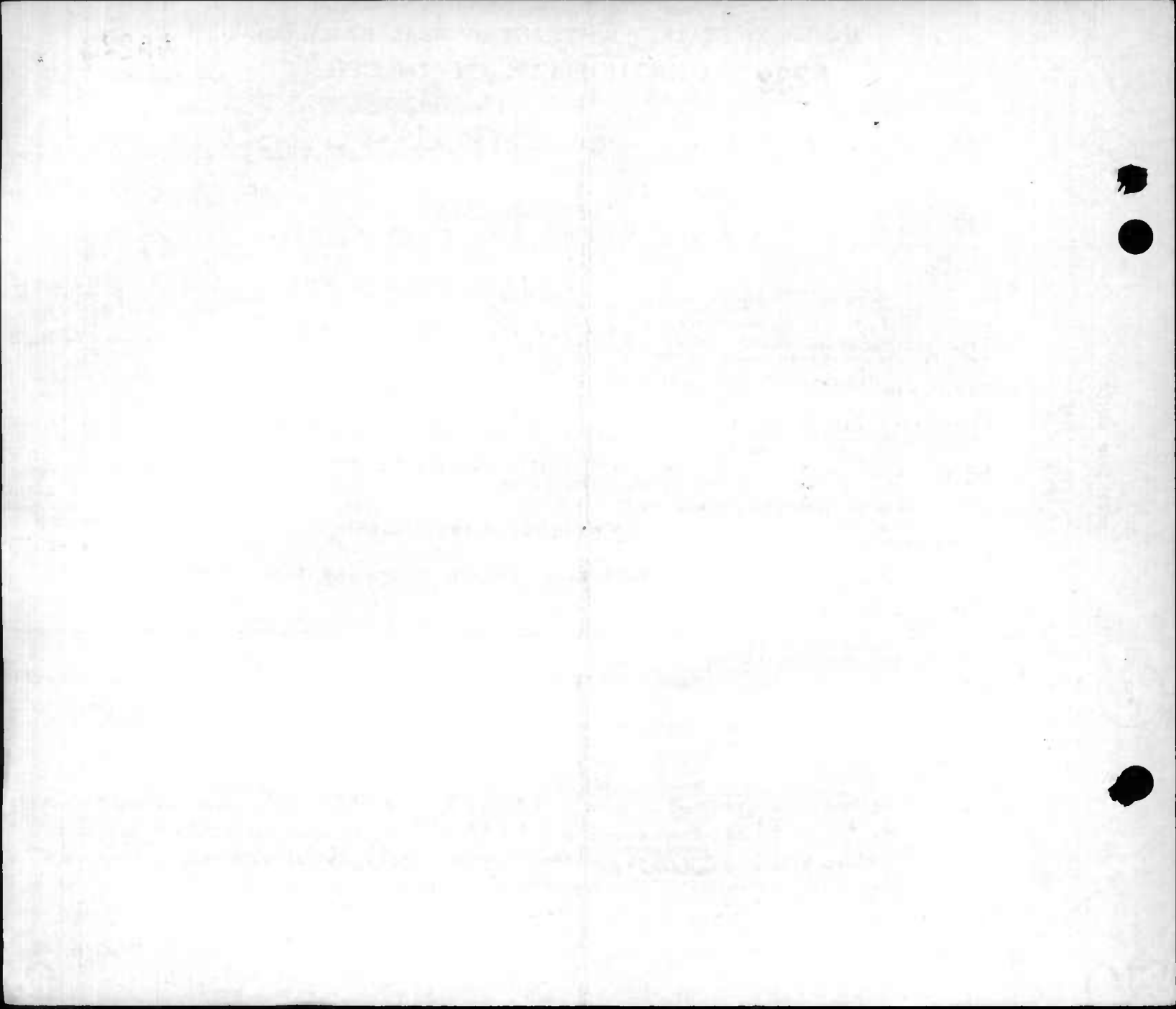
ADDRESS

July 2, 1955R.W.Geo. J. Gonce4001 Ritchie HgwyBalto. 25, Md

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

05224

5233

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 24

1. PLACE OF DEATH - COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pasadena</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u> 03-52-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Bethesda Creek, Bal. Haven Beach.</u>		STREET ADDRESS (If rural, give location) <u>26-N. Prospect Ave.</u>	
3. NAME OF DECEASED (First) <u>Edward</u> (Middle) <u>Demus</u> (Last) <u>Boylan</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>5</u> (Year) <u>1955</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1/31/95</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Refined Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <u>John Boylan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-03-2038</u>	
11. BIRTHPLACE (State or foreign country) <u>Westminster, Md.</u>		14. MOTHER'S MAIDEN NAME <u>Florence Morgan</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Anna Boylan (wife)</u>			

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

9298  
Immediate cause

(a)

Accidental Drowning

INTERVAL BETWEEN ONSET AND DEATH

Sudden

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Bethesda Creek - Bal. Haven Beach - Pasadena, D.C.</u>		(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>6/5/55 - 1:20 p.m.</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR? <u>Drowning</u>			

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>6/8/55</u>	<u>Bethesda Creek</u>	<u>Bethesda Creek - Pasadena, D.C.</u>	<u>Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR		
<u>June 9, 1955</u>	<u>L. J. D'Alba</u>	<u>Mac Nabh &amp; Son</u> <u>Catonsville Md</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 13 1955

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05225

5234

## CERTIFICATE OF DEATH

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Mayo</u>		<u>91 years</u>		TOWN <u>Mayo, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00							
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>Frank</u>		(Middle) <u>Lee</u>		(Last) <u>Brashears</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>		8. DATE OF BIRTH <u>Jan. 4, 1864</u>	
				9. AGE last birthday <u>91</u> yrs.		10. IF UNDER 1 YEAR (Month) (Day) (Year) <u>June 23 55</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Oysterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fishing</u>		11. BIRTHPLACE (State or foreign country) <u>Anne Arundel Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Frank Brashears</u>				14. MOTHER'S MAIDEN NAME <u>Eugenia Purdy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Earl Brashears, Mayo, Md.</u>			
15. <u>4</u>							
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>Myocardial Failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Heart Disease</u>				<u>10 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct.</u> , 19 <u>49</u> , to <u>June</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>June 23</u> , 19 <u>55</u> , and that death occurred at <u>9.30</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>Vincent Goned</u>				ADDRESS (Street, city, town, state) <u>Mayo, Md.</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 27, 55</u>		NAME OF CEMETERY OR CREMATORY <u>Mayo Memorial Cmet.</u>		LOCATION (City, town, or county) (State) <u>Mayo, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Edward Robinson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ben J. Hopping</u>		ADDRESS <u>Chingale, Md.</u>	
DATE <u>6/27/55</u>				<u>HOPPING FUNERAL HOME</u>			



CERTIFICATE OF DEATH

1954

Reg. Dist. No.

NAME	John Arnold
AGE	51 years
SEX	Male
RACE	White
DATE OF BIRTH	1903
PLACE OF BIRTH	Massachusetts
EDUCATION	High School
RELIGION	Protestant
MARRIAGE	Married
WIFE'S NAME	Anna Arnold
DATE OF MARRIAGE	1925
PLACE OF MARRIAGE	Massachusetts
DECEASED'S ADDRESS	123 Main St., Boston, Mass.
DECEASED'S OCCUPATION	Teacher
DECEASED'S STATUS	Single

DATE OF DEATH	June 23, 1954
TIME OF DEATH	10:30 AM
PLACE OF DEATH	Home
CAUSE OF DEATH	Heart Disease
IMMEDIATE CAUSE	Myocardial Infarction
UNDERLYING CAUSE	Coronary Artery Disease
DECEASED'S CONDITION	Good
DECEASED'S MENTAL STATE	Normal
DECEASED'S PHYSICAL STATE	Good
DECEASED'S SOCIAL STATE	Good
DECEASED'S ECONOMIC STATE	Good
DECEASED'S EDUCATIONAL STATE	Good
DECEASED'S OCCUPATIONAL STATE	Good
DECEASED'S RELIGIOUS STATE	Good
DECEASED'S MARITAL STATE	Good
DECEASED'S FAMILY STATE	Good
DECEASED'S COMMUNITY STATE	Good
DECEASED'S NATIONAL STATE	Good
DECEASED'S INTERNATIONAL STATE	Good
DECEASED'S COSMOPOLITAN STATE	Good
DECEASED'S UNIVERSAL STATE	Good

DECEASED'S SIGNATURE	John Arnold
DECEASED'S ADDRESS	123 Main St., Boston, Mass.
DECEASED'S OCCUPATION	Teacher
DECEASED'S STATUS	Single
DECEASED'S MENTAL STATE	Normal
DECEASED'S PHYSICAL STATE	Good
DECEASED'S SOCIAL STATE	Good
DECEASED'S ECONOMIC STATE	Good
DECEASED'S EDUCATIONAL STATE	Good
DECEASED'S OCCUPATIONAL STATE	Good
DECEASED'S RELIGIOUS STATE	Good
DECEASED'S MARITAL STATE	Good
DECEASED'S FAMILY STATE	Good
DECEASED'S COMMUNITY STATE	Good
DECEASED'S NATIONAL STATE	Good
DECEASED'S INTERNATIONAL STATE	Good
DECEASED'S COSMOPOLITAN STATE	Good
DECEASED'S UNIVERSAL STATE	Good

DECEASED'S SIGNATURE	John Arnold
DECEASED'S ADDRESS	123 Main St., Boston, Mass.
DECEASED'S OCCUPATION	Teacher
DECEASED'S STATUS	Single
DECEASED'S MENTAL STATE	Normal
DECEASED'S PHYSICAL STATE	Good
DECEASED'S SOCIAL STATE	Good
DECEASED'S ECONOMIC STATE	Good
DECEASED'S EDUCATIONAL STATE	Good
DECEASED'S OCCUPATIONAL STATE	Good
DECEASED'S RELIGIOUS STATE	Good
DECEASED'S MARITAL STATE	Good
DECEASED'S FAMILY STATE	Good
DECEASED'S COMMUNITY STATE	Good
DECEASED'S NATIONAL STATE	Good
DECEASED'S INTERNATIONAL STATE	Good
DECEASED'S COSMOPOLITAN STATE	Good
DECEASED'S UNIVERSAL STATE	Good

DECEASED'S SIGNATURE	John Arnold
DECEASED'S ADDRESS	123 Main St., Boston, Mass.
DECEASED'S OCCUPATION	Teacher
DECEASED'S STATUS	Single
DECEASED'S MENTAL STATE	Normal
DECEASED'S PHYSICAL STATE	Good
DECEASED'S SOCIAL STATE	Good
DECEASED'S ECONOMIC STATE	Good
DECEASED'S EDUCATIONAL STATE	Good
DECEASED'S OCCUPATIONAL STATE	Good
DECEASED'S RELIGIOUS STATE	Good
DECEASED'S MARITAL STATE	Good
DECEASED'S FAMILY STATE	Good
DECEASED'S COMMUNITY STATE	Good
DECEASED'S NATIONAL STATE	Good
DECEASED'S INTERNATIONAL STATE	Good
DECEASED'S COSMOPOLITAN STATE	Good
DECEASED'S UNIVERSAL STATE	Good

DECEASED'S SIGNATURE	John Arnold
DECEASED'S ADDRESS	123 Main St., Boston, Mass.
DECEASED'S OCCUPATION	Teacher
DECEASED'S STATUS	Single
DECEASED'S MENTAL STATE	Normal
DECEASED'S PHYSICAL STATE	Good
DECEASED'S SOCIAL STATE	Good
DECEASED'S ECONOMIC STATE	Good
DECEASED'S EDUCATIONAL STATE	Good
DECEASED'S OCCUPATIONAL STATE	Good
DECEASED'S RELIGIOUS STATE	Good
DECEASED'S MARITAL STATE	Good
DECEASED'S FAMILY STATE	Good
DECEASED'S COMMUNITY STATE	Good
DECEASED'S NATIONAL STATE	Good
DECEASED'S INTERNATIONAL STATE	Good
DECEASED'S COSMOPOLITAN STATE	Good
DECEASED'S UNIVERSAL STATE	Good

BUREAU V. 1

JUN 29 1955

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05226

5235

## CERTIFICATE OF DEATH

Reg. Dist. No. 27

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
CITY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Prince George</u>			
OR (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR			
TOWN <u>Ft George G Meade</u>		TOWN <u>Laurel</u>		STREET ADDRESS (if rural give location)		<u>1641-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. Army Hospital</u>		LENGTH OF STAY (in this place) <u>5 months</u>		STREET ADDRESS <u>226 9th Street</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>DONALD HAROLD BRAY</u>				<u>June 18 19 55</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>	<b>IF UNDER 24 HRS.</b>	
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>June 16 1955</u>	<u>0</u> yrs.	Months <u>1</u> Days <u>21</u>	Hours <u>22</u> Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
				<u>Maryland</u>		<u>U.S.A.</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>William H. Bray</u>				<u>Cathrine Whiteman</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>No</u>				<u>William H Bray 226 9th Street</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<u>776X</u> IMMEDIATE CAUSE (A) <u>Prematurity</u>				<u>Laurel, Maryland</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>				<u>None</u>			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b>			
<u>None</u>				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, or of INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
				<u>Laurel, Maryland</u>			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>16 June</u>, 19<u>55</u>, to <u>18 June</u>, 19<u>55</u>, that I last saw the deceased alive on <u>18 June</u>, 19<u>55</u>, and that death occurred at <u>1122</u> M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>ROBERT MOORE, CAPT. MC</u>				<b>ADDRESS</b> (Street, city, town, state)		<b>DATE SIGNED</b>	
<u>Robert Moore</u> M.D.				<u>U. S. ARMY HOSPITAL, Ft. G.G. Meade</u>		<u>18 June 55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>Burial</u>		<u>21 June 1955</u>		<u>Rest Cemetery</u>		<u>Fort G. G. Meade, Md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>18 June 1955</u>		<u>W.L. Saylor, 1st LT MSC</u>		<u>Chaplain Herbert MacCambia</u>			

2065211260

# CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. OCCUPATION		6. CAUSE OF DEATH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES	
13. MEDICAL CERTIFICATE		14. MEDICAL CERTIFICATE		15. MEDICAL CERTIFICATE	
16. MEDICAL CERTIFICATE		17. MEDICAL CERTIFICATE		18. MEDICAL CERTIFICATE	
19. MEDICAL CERTIFICATE		20. MEDICAL CERTIFICATE		21. MEDICAL CERTIFICATE	
22. MEDICAL CERTIFICATE		23. MEDICAL CERTIFICATE		24. MEDICAL CERTIFICATE	
25. MEDICAL CERTIFICATE		26. MEDICAL CERTIFICATE		27. MEDICAL CERTIFICATE	
28. MEDICAL CERTIFICATE		29. MEDICAL CERTIFICATE		30. MEDICAL CERTIFICATE	
31. MEDICAL CERTIFICATE		32. MEDICAL CERTIFICATE		33. MEDICAL CERTIFICATE	
34. MEDICAL CERTIFICATE		35. MEDICAL CERTIFICATE		36. MEDICAL CERTIFICATE	
37. MEDICAL CERTIFICATE		38. MEDICAL CERTIFICATE		39. MEDICAL CERTIFICATE	
40. MEDICAL CERTIFICATE		41. MEDICAL CERTIFICATE		42. MEDICAL CERTIFICATE	
43. MEDICAL CERTIFICATE		44. MEDICAL CERTIFICATE		45. MEDICAL CERTIFICATE	
46. MEDICAL CERTIFICATE		47. MEDICAL CERTIFICATE		48. MEDICAL CERTIFICATE	
49. MEDICAL CERTIFICATE		50. MEDICAL CERTIFICATE		51. MEDICAL CERTIFICATE	
52. MEDICAL CERTIFICATE		53. MEDICAL CERTIFICATE		54. MEDICAL CERTIFICATE	
55. MEDICAL CERTIFICATE		56. MEDICAL CERTIFICATE		57. MEDICAL CERTIFICATE	
58. MEDICAL CERTIFICATE		59. MEDICAL CERTIFICATE		60. MEDICAL CERTIFICATE	
61. MEDICAL CERTIFICATE		62. MEDICAL CERTIFICATE		63. MEDICAL CERTIFICATE	
64. MEDICAL CERTIFICATE		65. MEDICAL CERTIFICATE		66. MEDICAL CERTIFICATE	
67. MEDICAL CERTIFICATE		68. MEDICAL CERTIFICATE		69. MEDICAL CERTIFICATE	
70. MEDICAL CERTIFICATE		71. MEDICAL CERTIFICATE		72. MEDICAL CERTIFICATE	
73. MEDICAL CERTIFICATE		74. MEDICAL CERTIFICATE		75. MEDICAL CERTIFICATE	
76. MEDICAL CERTIFICATE		77. MEDICAL CERTIFICATE		78. MEDICAL CERTIFICATE	
79. MEDICAL CERTIFICATE		80. MEDICAL CERTIFICATE		81. MEDICAL CERTIFICATE	
82. MEDICAL CERTIFICATE		83. MEDICAL CERTIFICATE		84. MEDICAL CERTIFICATE	
85. MEDICAL CERTIFICATE		86. MEDICAL CERTIFICATE		87. MEDICAL CERTIFICATE	
88. MEDICAL CERTIFICATE		89. MEDICAL CERTIFICATE		90. MEDICAL CERTIFICATE	
91. MEDICAL CERTIFICATE		92. MEDICAL CERTIFICATE		93. MEDICAL CERTIFICATE	
94. MEDICAL CERTIFICATE		95. MEDICAL CERTIFICATE		96. MEDICAL CERTIFICATE	
97. MEDICAL CERTIFICATE		98. MEDICAL CERTIFICATE		99. MEDICAL CERTIFICATE	
100. MEDICAL CERTIFICATE		101. MEDICAL CERTIFICATE		102. MEDICAL CERTIFICATE	

**RECEIVED**  
JUN 28 1955  
BUREAU V. S.

NOTARY PUBLIC  
STATE OF MARYLAND  
BALTIMORE  
I, the undersigned, a Notary Public for the State of Maryland, do hereby certify that the foregoing is a true and correct copy of the original of the above and subscribed Certificate of Death, as the same appears from the records of the Department of Health of the State of Maryland, and that the same has been duly filed for record in the office of the Notary Public for the State of Maryland, at Baltimore, Maryland, this 28th day of June, 1955.

NOTARY PUBLIC  
STATE OF MARYLAND  
BALTIMORE

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5236

## CERTIFICATE OF DEATH

05227

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL end give nearest town)			
TOWN <u>Crownsville</u>		<u>1yr.36 days</u>		TOWN <u>Baltimore City</u>		<u>3V01.4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>1006 S. Eutaw Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Cocker</u>		(Middle)		(Last) <u>Brown</u>		(Month) <u>6</u> (Day) <u>12</u> (Year) <u>19 55</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>Negro</u>	<u>Single</u>	<u>8/29/31</u>	<u>23</u> yrs.	Months <u>—</u>	Days <u>—</u>	Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Laborer</u>		<u>Unk.</u>		<u>Maryland</u>		<u>U. S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Unknown</u>				<u>Elischer Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Unk.</u>		<u>Unk.</u>		<u>Hospital Records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<u>6 hours</u>	
420.1 IMMEDIATE CAUSE (A) <u>Acute myocardial Infarction</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH						<u>Over 12 months</u>	
<u>Chronic Glomerulonephritis with Anasarca</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
<u>—</u>		<u>—</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
<u>—</u>		<u>—</u>		<u>—</u>		<u>—</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR?			
<u>—</u>		<u>M.</u>		<u>—</u>			
22. I hereby certify that I attended the deceased from <u>5/7</u> , 19 <u>54</u> , to <u>6/12</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6/12</u> , 19 <u>55</u> , and that death occurred at <u>8.20</u> A.M. from the causes and on the date stated above.							
SIGNATURE		(L. Benedict M.D.)		ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>[Signature]</u>		<u>[Signature]</u>		<u>Crownsville, Md.</u>		<u>6/12/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6-16-55</u>		<u>Arbutus Cemetery</u>		<u>Balto. City</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
<u>[Signature]</u>		<u>H. M. Joyce</u>		<u>E.O. Wilson, Baltimore, Md.</u>			
DATE		<u>June 14, 1955</u>		<u>1000 Brantley Ave.</u>			

# CERTIFICATE OF DEATH

2336

1. PLACE OF DEATH

2. NAME OF DECEASED

3. SEX

4. AGE

5. DATE OF DEATH

6. TIME OF DEATH

7. PLACE OF BIRTH

8. OCCUPATION

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF FUNERAL HOME

16. SIGNATURE OF OTHER

17. SIGNATURE OF OTHER

BUREAU V. S.

JUN 15 1955

RECEIVED

AMERICAN

AMERICAN



5237

## CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Anne Arundel</u>	MARYLAND	STATE <u>Md-</u>	COUNTY <u>A.A.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Shoreham Beach</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Shoreham Beach</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Residence</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Alice</u>	(Middle) <u>Wooisa</u>	(Last) <u>Burdick</u>	(Month) <u>6</u> (Day) <u>11</u> (Year) <u>1955</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>February 8, 1901</u>
9. AGE last birthday: <u>54</u> yrs.		10. MONTHS <u>11</u> DAYS <u>19</u> HRS. <u>55</u>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>At Home</u>	
11. BIRTHPLACE (State or foreign country): <u>Bridgeport Connecticut</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Charles Briggs Scott</u>		14. MOTHER'S MAIDEN NAME: <u>Mabel MacDougal</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>578108460</u>	
17. INFORMANT & ADDRESS: <u>Mr. Charles D. Scott</u>			
		<u>2835 N. Ridgeway Ave., Chicago, Ill.</u>	

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<u>443X</u>		<u>17d</u>
Immediate cause (a) <u>Cerebral Vascular Accident</u>		
Antecedent causes (s) (b) <u>Hypertensive C.V.D.</u>		<u>many years</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)		

11. OTHER SIGNIFICANT CONDITIONS		20. AUTOPSY ?	
Conditions contributing to the death but not related to the disease or condition causing death.		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION: <u>—</u>		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
SUICIDE			
HOMICIDE			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED	
		While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 5/15, 1955, to 6/4, 1955, that I last saw the deceased alive on 5/18, 1955, and that death occurred at ?, from the causes and on the date stated above.

SIGNATURE (Degree or title) Frank M. Shipley M.D. ADDRESS Annapolis, Md. 6/18/55

DATE SIGNED 6/18/55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>June 14, 1955</u>	<u>Arlington National</u>	<u>Arlington, Virginia</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	
<u>6/18/55</u>	<u>Amanda Dunney</u>	<u>W. W. Chambers, Riverdale, Md.</u>	
<u>6/28/55 Edward Robinson</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU VI 31

JUL 5 1955

RECEIVED



5238

## CERTIFICATE OF DEATH

Reg. Dist. No. 23

Item 8, Film G182 6-16-55 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>aa</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>aa</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Linthicum</u>		<u>10 yrs.</u>		TOWN <u>Same</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>39 Potapscow</u>				STREET ADDRESS (If rural give location) <u>39 Potapscow Rd</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Wm</u> (Middle) <u>Carol</u> (Last) <u>Butler</u>				(Month) <u>June</u> (Day) <u>9</u> (Year) <u>1955</u>			
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>mar</u>	8. DATE OF BIRTH <u>July 5, 1916</u>	9. AGE last birthday <u>40</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk (Jr) Davis Chemical</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm Mathew Butler</u>				14. MOTHER'S MAIDEN NAME <u>Helen Derschinger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>217-05-5182</u>		17. INFORMANT & ADDRESS <u>Wife - Bertha - Butler</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE (A) <u>Cardio-Vascular Disease</u>						<u>6 mo -</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>none.</u>							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>5:30</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 11, 1955</u> , to <u>Jun 9, 1955</u> , that I last saw the deceased alive on <u>6/9</u> , 19 <u>55</u> , and that death occurred at <u>5:30</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Chas. L. Ball</u>		DATE THEREOF <u>June 11/55</u>		NAME OF CEMETERY OR CREMATORY <u>Meadowridge</u>		LOCATION (City, town, or county) <u>Wash. Blvd.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE		DATE SIGNED <u>6/9/55</u>	
DATE <u>June 10, 1955</u>		REGISTRAR'S SIGNATURE <u>Caldwell Wadnuff</u>		ADDRESS <u>Linthicum</u>		STATE <u>Md.</u>	

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

# CERTIFICATE OF DEATH

1955

DATE OF DEATH

PLACE OF DEATH

FAMILY

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

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JUN 13 1955

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5239

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

COUNTY Joseph A. Co MARYLAND  
 CITY (If outside corporate limits, write RURAL LENGTH OF STAY  
 OR and give nearest town) AA Co Md (in this place)  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS  
Elvaton

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md COUNTY AA  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR AA Co Md  
 TOWN Elvaton  
 STREET ADDRESS (If rural give location)  
Elvaton

## 3. NAME OF DECEASED:

(First) Joseph (Middle) R. C (Last) agaw  
 (Type or Print)

## 4. DATE OF DEATH:

(Month) (Day) (Year)  
June 26 1955

## 5. SEX:

M

## 6. COLOR OR RACE:

W

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

W

## 8. DATE OF BIRTH:

Feb 24 1881

## 9. AGE last birthday:

74 yrs.

## 10. IF UNDER 1 YEAR

Months Days Hours Min.

## 10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired:

## 10b. KIND OF BUSINESS OR INDUSTRY:

## 11. BIRTHPLACE (State or foreign country):

Md

## 12. CITIZEN OF WHAT COUNTRY?

## 13. FATHER'S NAME:

James Cagaw

## 14. MOTHER'S MAIDEN NAME:

Sarah Johnson

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unk.) (If Yes, give war or dates of service)

Y

## 16. SOCIAL SECURITY No.:

## 17. INFORMANT &amp; ADDRESS:

Joseph Cagaw Elvaton AA Co Md

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1  
 Immediate cause

(a) Congestive Heart Failure

Interval Between Onset And Death

1 week

Antecedent causes (s)  
 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Arteriosclerotic Cardiovascular disease

2 years

(c)

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

cerebral hemorrhage with left hemiplegia

2 1/2 years

## 19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE (Specify)

## PLACE (Home, farm, factory, street, office bldg., etc.)

## (CITY OR TOWN)

## (COUNTY)

## (STATE)

## TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

## HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 18, 1953, to June 26, 1955, that I last saw the deceased alive on June 26, 1955, and that death occurred at 9:15 P.M. from the causes and on the date stated above.

SIGNATURE R. M. McHughlin

(Degree or title) M.D.

ADDRESS Pasadena, Md.

DATE SIGNED June 26, 1955

## 23. BURIAL, CREMATION, REMOVAL (Specify)

Burial

## DATE THEREOF

6/29/55

## NAME OF CEMETERY OR CREMATORY

Hall Church Yard

## LOCATION (City, town, or county)

AA Co Md

## (State)

## DATE RECD BY LOCAL REGISTRAR

6-29-55

## REGISTRAR'S SIGNATURE

W. H. H. H. H.

## 24. FUNERAL DIRECTOR

James L. Brown

## ADDRESS

108 W. Montgomery St

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

05231

5240

2411 N. Charles Street, Baltimore

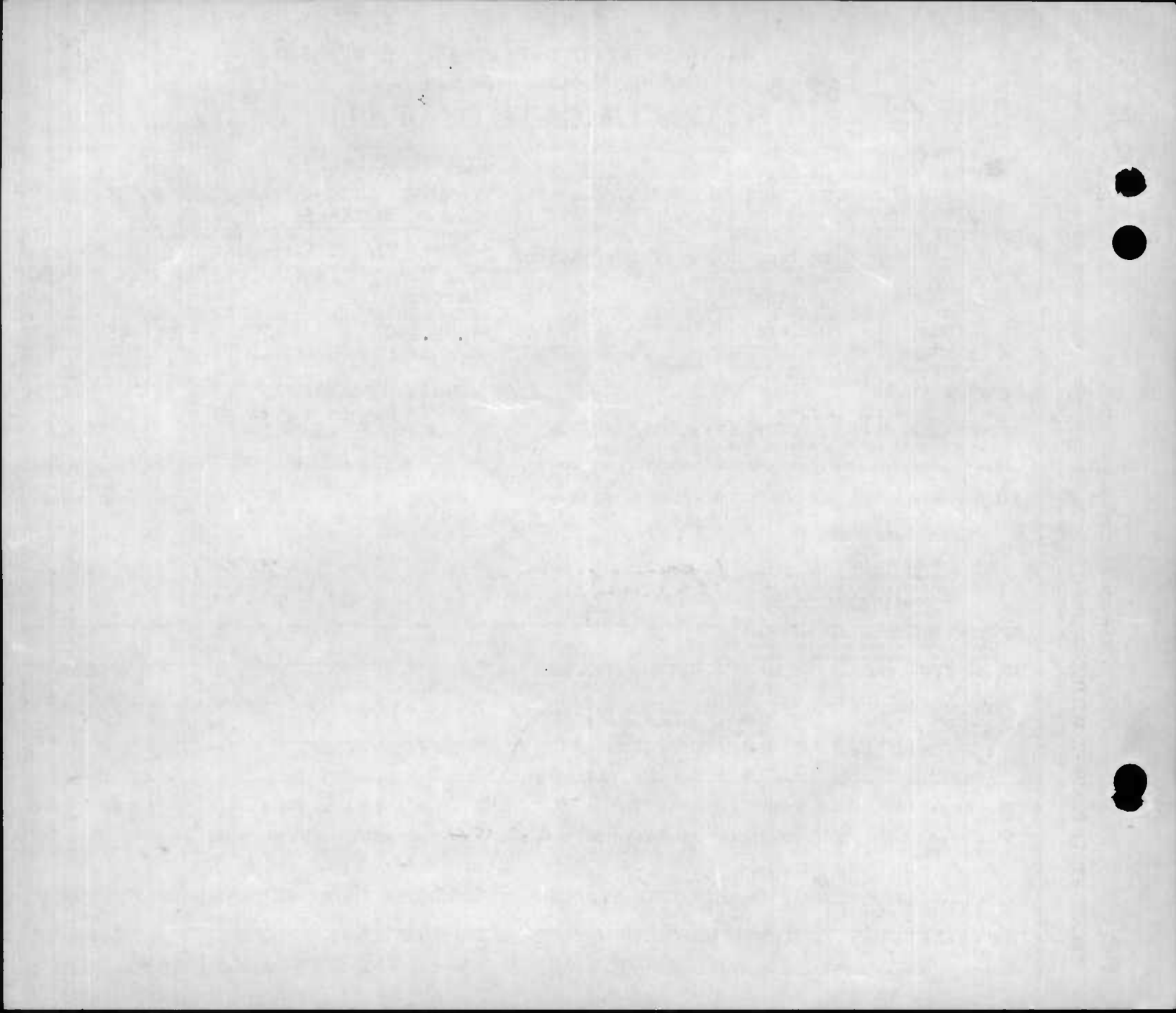
## CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH- COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> <u>3Y01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>92 Maryland House of Correction</u>		STREET ADDRESS (If rural, give location) <u>714 W. Fairmount St/</u>	
3. NAME OF DECEASED (First) <u>James</u> (Middle) (Last) <u>Carter</u>		4. DATE OF DEATH (Month) <u>6</u> (Day) <u>18</u> (Year) <u>1955</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Dec. 12, 1907</u>
9. AGE last birthday <u>47</u> yrs. If under 1 year Months <u>8</u> Days <u>3</u>		If under 24 hrs. Hours <u>5</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Carter</u>		14. MOTHER'S MAIDEN NAME <u>Nannie Hughes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>John Carter 1710 E. Spanglers Rd.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>022X</u> Immediate cause (a) <u>Rupture left Carotid Aneurysm</u> Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Syphilis - treatment J.H.H. 1927 with Poly- thene wrapping of left Carotid Aneurysm</u> (c) <u>no m. 2-13-52</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at? Not While Work <input type="checkbox"/> At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-11</u> ....., 1955, to <u>6-17</u> ....., 1955, that I last saw the deceased alive on <u>6-16</u> ....., 1955, and that death occurred at <u>10:35 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Robert B. Taylor MD</u>		ADDRESS <u>Maryland House of Correction</u> DATE SIGNED	
23. BURIAL, CREMATION REMOVALS (Specify)		DATE THEREOF <u>6-24-55</u> NAME OF CEMETERY OR CREMATORY <u>St. Albans</u> LOCATION (City, town, or county) <u>Baltimore</u> (State) <u>Md.</u>	
DATE REC'D BY LOCAL REG. <u>8-23-55</u>		REGISTRAR'S SIGNATURE <u>G. W. Neale</u> 24. FUNERAL DIRECTOR <u>Thomas C. Kellon, Jr. 1303 Lexington St.</u> ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **05232**  
**5241** CERTIFICATE OF DEATH

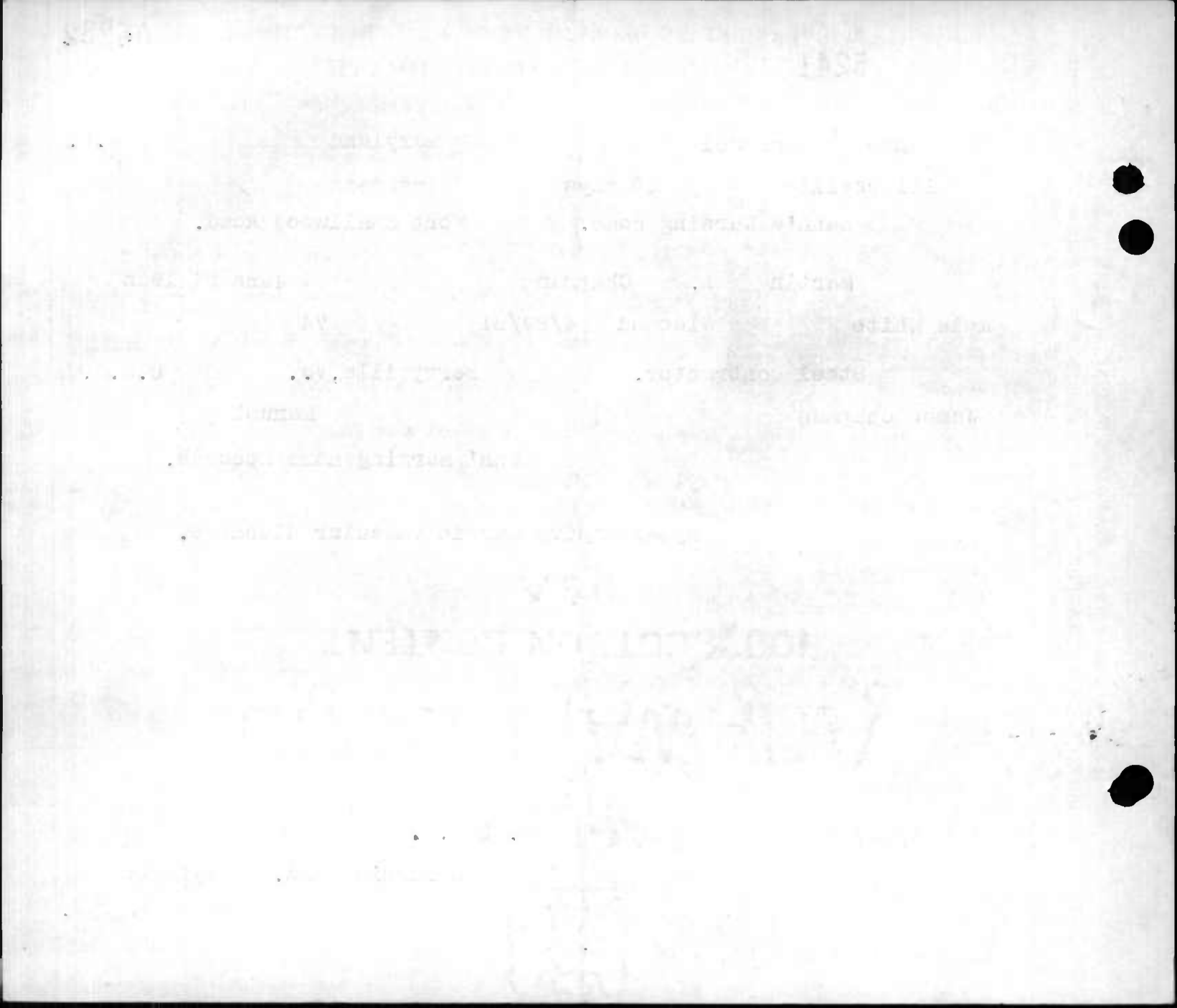
Reg. Dist. No. **21**

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Anne Arundel</b> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Millersville</b> LENGTH OF STAY (in this place) <b>50 days</b>				STATE <b>Maryland</b> COUNTY <b>A.A.</b> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Pasadena</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Sann's Nursing Home.</b>				STREET ADDRESS (If rural give location) <b>Fort Smallwood Road.</b>			
3. NAME OF DECEASED: (First) (Middle) (Last) <b>Martin L. Chapman</b>				4. DATE OF DEATH: (Month) (Day) (Year) <b>June 24 1955</b>			
5. SEX: <b>Male</b>		6. COLOR OR RACE: <b>White</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>		8. DATE OF BIRTH: <b>4/22/81</b>	
9. AGE last birthday: <b>74</b> yrs.		10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <b>Steel Contractor.</b>		10b. KIND OF BUSINESS OR INDUSTRY: <b>Berryville, Va.</b>		9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country): <b>U.S.A.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME: <b>James Chapman</b>				14. MOTHER'S MAIDEN NAME: <b>Manuel</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <b>Sann' Nursing Home Records.</b>			
(If Yes, give war or dates of service)							
18. MEDICAL CERTIFICATION							Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>443X</b> Immediate cause (a) <b>Hypertensive Cardio Vascular diseases.</b> DUE TO Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO (c)							?
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <b>0</b>				19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>6/1/55</b> , 19....., to <b>6/24/55</b> , 19....., that I last saw the deceased alive on <b>6/23/55</b> 19....., and that death occurred at <b>9.15 A.M.</b> from the causes and on the date stated above.							
SIGNATURE <i>Kustave K. Paubert</i> (Degree or title)				ADDRESS DATE SIGNED <b>Glen Burnie Md. 6/24/55</b>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>June 27, 1955</b>		<b>Meadowridge Memorial</b>		<b>Washington Blvd. Md.</b>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <i>D.W. Hedlin</i>		24. FUNERAL DIRECTOR		ADDRESS	
<b>6-27-55</b>				<b>KRAUSE FUNERAL HOME</b>		<b>12163 Charles St.</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05233

5242

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>A.A.</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Severn</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Camp Meade Rd.</u>		<u>Life</u>		STREET ADDRESS (If rural give location) <u>Camp-Meade, Road</u>			
3. NAME OF DECEASED: (Type or Print) <u>Josiah</u> (First) <u>Clark</u> (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <u>5/1/55</u> 19			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>3/12/72</u>	9. AGE last birthday <u>83</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Farmer</u>		11. BIRTHPLACE (State or foreign country): <u>Severn, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Wm. Henry Clark</u>				14. MOTHER'S MAIDEN NAME: <u>Harriet Griffith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>He No</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS: <u>Edward Clark (son)</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE				(A) <u>Cerebral Haemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sept. '54</u>	
ANTECEDENT CAUSE (S)				(B) <u>Arterio-Sclerosis</u>		<u>10 yrs -</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic Nephritis</u>							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb</u> , 19 <u>50</u> , to <u>6/1/55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6/1/55</u> , 19 <u>55</u> , and that death occurred at <u>4</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Chas. L. Ball</u>		M. D. <u>L. L. Linticum</u>		DATE SIGNED <u>6/1/55</u>			
23. BURIAL, CREMATION, REMOVAL, (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 3, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Friendship</u>		LOCATION (City, town, or county) (State) <u>A.A.Co., Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>June 2, 1955</u>		REGISTRAR'S SIGNATURE <u>Clay M. Haslup</u>		24. FUNERAL DIRECTOR <u>R. D. Light</u>		ADDRESS <u>Sh. Burns, Md.</u>	

BUREAU V. 81

JUN 6 1955

RECEIVED

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5243

## CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Anne Arundel</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Anne Arundel</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Glen Burnie</i>	LENGTH OF STAY (in this place) <i>6 mo.</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Green Gables, Md.</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Playa Mann Nursing Home Box 367-A, Rt. 2, Glen Burnie, Md.</i>		STREET ADDRESS (If rural give location) <i>Box 67, Rt. 1 - Pasadena P.O., Md.</i>	

3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <i>IDA</i>	(Middle) <i>LOUISE</i>	(Last) <i>CLEWELL</i>	(Month) <i>June</i> (Day) <i>5</i> (Year) <i>1955</i>
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Widowed</i>	8. DATE OF BIRTH: <i>June 3, 1871</i>
9. AGE last birthday: <i>84</i> yrs.		10. IF UNDER 1 YEAR: Months _____ Days _____	11. IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>none</i>	11. BIRTHPLACE (State or foreign country): <i>Richmond, Virginia</i>
12. CITIZEN OF WHAT COUNTRY? <i>yes - USA</i>		13. FATHER'S NAME: <i>not known</i>	
14. MOTHER'S MAIDEN NAME: <i>not known</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>	
16. SOCIAL SECURITY No.: <i>none</i>		17. INFORMANT & ADDRESS: <i>No living relatives. Mr. Rodman Gilbert (boarder) Box 67, Rt. 1, Pasadena P.O., Md.</i>	

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<i>442X</i> Immediate cause (a) <i>Uremia - terminal</i>		<i>2 mo.</i>
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <i>Arteriosclerotic Cardio Vascular-Renal Disease</i>		<i>10 yrs.</i>
(c) <i>Generalized arteriosclerosis</i>		<i>10 yrs.</i>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Hemiplegia - right side</i>		<i>7 mo.</i>
19a. DATE OF OPERATION: <i>none</i>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify) <i>None</i>	PLACE (Home, farm, factory, street, office bldg., etc.) <i>none</i>	(CITY OR TOWN) _____ (COUNTY) _____ (STATE) _____
TIME (Month) (Day) (Year) (Hour) OF INJURY _____ m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? _____

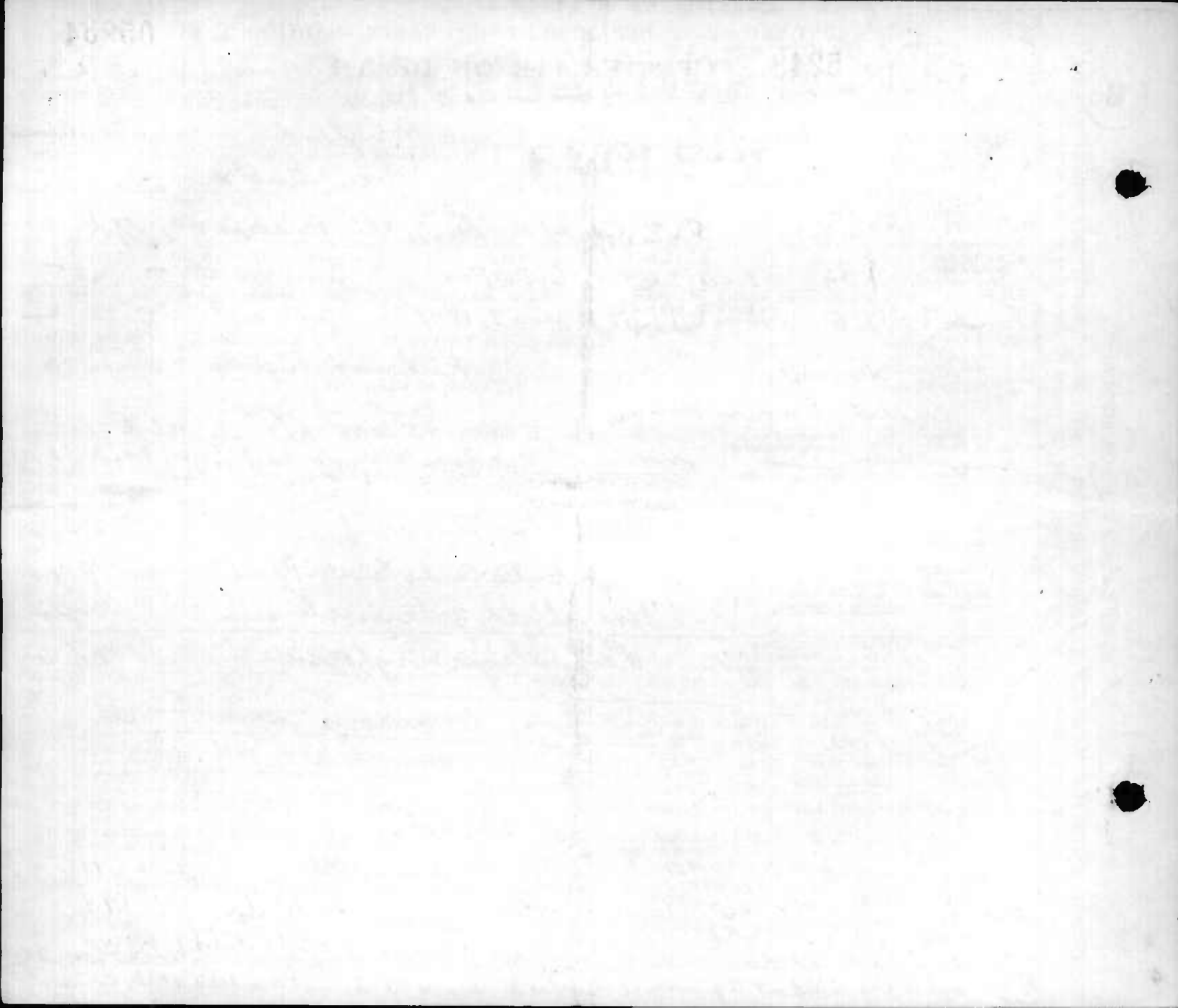
22. I hereby certify that I attended the deceased from ..... 19....., to *June 6*, 19 *55*, that I last saw the deceased alive on ..... 19....., and that death occurred at *1:45 A.M.*, from the causes and on the date stated above.

SIGNATURE <i>H. F. Manuzak M.D.</i>	(Degree or title)	ADDRESS <i>901 Edgerly Rd, Glen Burnie, Md.</i>	DATE SIGNED <i>June 5, 1955</i>
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	DATE THEREOF <i>6/8/55</i>	NAME OF CEMETERY OR CREMATORY <i>Glen Haven</i>	LOCATION (City, town, or county) (State) <i>A. A. Co. Md.</i>
DATE REC'D BY LOCAL REGISTRAR <i>58</i>	REGISTRAR'S SIGNATURE <i>[Signature]</i>	24. FUNERAL DIRECTOR <i>George J. Young</i>	ADDRESS <i>4001 Ritchie Hwy</i>

Note: This patient had been under the care of Dr. J. Taler of Glen Burnie for the last 6 months and I was called out to pronounce her dead, because he was not available at the time.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5212

## CERTIFICATE OF DEATH

05235

Reg. Dist. No. 21

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>A.A. Co.</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>A.A. Co.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>10 ANNA POLIS</u>				TOWN <u>10 ANNA POLIS</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>103 A.A. General Hosp.</u>				STREET ADDRESS (If rural give location) <u>83 Northwest ST</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>ELLA</u> (Middle) <u>A.</u> (Last) <u>Colbert</u>				(Month) <u>6</u> (Day) <u>30</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	10. IF UNDER 1 YEAR		
<u>Female</u>	<u>Colored</u>	<u>Married</u>	<u>3-18-1894</u>	<u>63</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				<u>MARYLAND</u>		<u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph STANBURY</u>				14. MOTHER'S MAIDEN NAME <u>Delia STANBURY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Beatrice McKinnis 327 Lafayette Ave. Anna</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
331X IMMEDIATE CAUSE (A) <u>Cerebro-vascular accident</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6-27-55</u> , to <u>6-30-55</u> , that I last saw the deceased alive on <u>6-28-55</u> , 19 <u>55</u> , and that death occurred at <u>6:50</u> M, from the causes and on the date stated above.							
SIGNATURE <u>U.T. Allen</u>				ADDRESS (Street, city, town, state) <u>62 Cathedral ST</u> DATE SIGNED <u>7-1-55</u>			
M.D. <u>U.T. Allen</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>7-5-55</u>		NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		LOCATION (City, town, or county) (State) <u>ANNA POLIS Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>U. Council</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese II</u> ADDRESS <u>108 W. Wash. ST ANNA POLIS, Md</u>			
DATE <u>7-7-1955</u>							

# CERTIFICATE OF DEATH

REG. DIST. NO.

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF FUNERAL HOME

14. SIGNATURE OF BURIAL SOCIETY

15. SIGNATURE OF CHURCH

16. SIGNATURE OF OTHER

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BUREAU V. S.

JUL 8 1955

RECEIVED

REGISTERED



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5213

## CERTIFICATE OF DEATH

05236

Reg. Dist. No. 21

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Q. A.</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Q. A.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>10 Annapolis</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>112 Archwood Ave</u>				STREET ADDRESS (If rural give location) <u>112 Archwood Ave</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Thomas J Cole Sr</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>6-1-1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec 29-1874</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Foreman Stable Grounds USNA</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Long Dale Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Patrick W. Cole</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Lighttholder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS <u>Thos J Cole Jr 2</u>			
<b>1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
177X IMMEDIATE CAUSE (A) <u>Carcinoma of the Prostate</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u> <u>Diagnosed</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Acute Dehydration of the Heart</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jun 1, 1955</u> 19 <u>55</u> , to <u>Jun 1, 1955</u> , that I last saw the deceased alive on <u>6/1/55</u> 19 <u>55</u> , and that death occurred at <u>5:40 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Elbert R Anderson</u>		M.D. <u>Annapolis Md</u>		ADDRESS (Street, city, town, state) <u>Annapolis Md</u>		DATE SIGNED <u>6/1/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6-4-55</u>		NAME OF CEMETERY OR CREMATORY <u>St Marys</u>		LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
24. REC'D BY REGISTRAR <u>June 3, 1955</u>		REGISTRAR'S SIGNATURE <u>J. O. Daniel</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John M Taylor Sons</u>		ADDRESS <u>Annapolis Md</u>	

# CERTIFICATE OF DEATH

2513

1. DECEASED'S NAME (Last, first, middle)

2. SEX  
 a. Male  
 b. Female

3. RACE  
 a. White  
 b. Negro  
 c. Other

4. DATE OF BIRTH  
 a. Year  
 b. Month  
 c. Day

5. PLACE OF BIRTH  
 a. State  
 b. County  
 c. City

6. DECEASED'S RESIDENCE  
 a. State  
 b. County  
 c. City

7. DECEASED'S OCCUPATION  
 a. Trade  
 b. Profession  
 c. Occupation

8. DECEASED'S MARITAL STATUS  
 a. Single  
 b. Married  
 c. Widowed  
 d. Divorced

9. DECEASED'S EDUCATION  
 a. Less than high school  
 b. High school  
 c. Some college  
 d. College or more

10. DECEASED'S RELIGION  
 a. None  
 b. Protestant  
 c. Catholic  
 d. Jewish  
 e. Other

11. DECEASED'S CAUSE OF DEATH  
 a. Disease  
 b. Injury  
 c. Poison  
 d. Other

12. DECEASED'S MANNER OF DEATH  
 a. Natural  
 b. Accidental  
 c. Suicide  
 d. Homicide  
 e. Undetermined

13. DECEASED'S PLACE OF DEATH  
 a. Home  
 b. Hospital  
 c. Prison  
 d. Other

14. DECEASED'S DATE OF DEATH  
 a. Year  
 b. Month  
 c. Day

15. DECEASED'S TIME OF DEATH  
 a. Hour  
 b. Minute

16. DECEASED'S AGE  
 a. At birth  
 b. At death

17. DECEASED'S SEX  
 a. Male  
 b. Female

18. DECEASED'S RACE  
 a. White  
 b. Negro  
 c. Other

19. DECEASED'S DATE OF BIRTH  
 a. Year  
 b. Month  
 c. Day

20. DECEASED'S PLACE OF BIRTH  
 a. State  
 b. County  
 c. City

21. DECEASED'S RESIDENCE  
 a. State  
 b. County  
 c. City

22. DECEASED'S OCCUPATION  
 a. Trade  
 b. Profession  
 c. Occupation

23. DECEASED'S MARITAL STATUS  
 a. Single  
 b. Married  
 c. Widowed  
 d. Divorced

BUREAU V. S.

JUN 6 1955

RECEIVED

**INSTRUCTIONS**

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

S. S. No.

212-16-2606

5244

**CERTIFICATE OF DEATH**

05237

Reg. Dist. No.

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>AA</u>		MARYLAND		STATE <u>MD</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Linthicum</u>		<u>30 yr.</u>		TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>404 Forrest View Rd.</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>Clarence</u> (Middle) <u>Conaway</u> (Last)				(Month) <u>June</u> (Day) <u>22</u> (Year) <u>1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>3/29/68</u>	9. AGE last birthday <u>87</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Boiler &amp; Ice</u>		11. BIRTHPLACE (State or foreign country) <u>Savage Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Conaway</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Keiffer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-16-2606-17</u>		17. INFORMANT & ADDRESS <u>Rosina Conaway (wife)</u>			
<b>18. MEDICAL CERTIFICATION</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<u>6/14/55</u>			
331X IMMEDIATE CAUSE (A) <u>Cerebral Haemorrhage</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio-Sclerosis</u>				<u>10 yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from <u>6/22</u>, 19<u>55</u>, to <u>6/22</u>, 19<u>55</u>, that I last saw the deceased alive on <u>6/22</u>, 19<u>55</u>, and that death occurred at <u>11:30 PM</u>, from the causes and on the date stated above.</b>							
SIGNATURE <u>Chas. L. Ball Jr.</u>				ADDRESS (Street, city, town, state) <u>M.D. Linthicum</u>		DATE SIGNED <u>6/22/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/25/55</u>		NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>		LOCATION (City, town, or county) <u>Pikeville, Md.</u>	
24. RECD BY REGISTRAR <u>June 27, 1955</u>		REGISTRAR'S SIGNATURE <u>Caldwell Woodruff</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Vickers &amp; Sons</u>		ADDRESS <u>Roche 17 Md</u>	

PLAN C

JUN 28 1955

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5214

## CERTIFICATE OF DEATH

05238

Reg. Dist. No.

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>A. A. Co</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>A. A. Co.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>10 ANNA POLIS</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BEST GATE</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>63 ANNE ARUNDEL GENERAL</u>				STREET ADDRESS (If rural give location) <u>2 Mabel Ave</u>		<u>1</u>	
<b>3. NAME OF DECEASED</b> (Type or Print) <u>ELIZABETH DAVIS</u>				<b>4. DATE OF DEATH</b> (Month) <u>6</u> (Day) <u>13</u> (Year) <u>1955</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>6-14-1904</u>	9. AGE last birthday <u>50</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Presser</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Shorts</u>				14. MOTHER'S MAIDEN NAME <u>Leslie Driver</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-12-0285</u>		17. INFORMANT & ADDRESS <u>FRANK DAVIS, 2 Mabel Ave, Best Gate</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <u>Internal hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Rupture of aortic aneurysm</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>  </u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>2</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>6-12-55</u> 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>6-11-55</u> , 19 <u>55</u> , to <u>6-13-55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6-12-55</u> , 19 <u>55</u> , and that death occurred at <u>6-13-55</u> AM, from the causes and on the date stated above.							
SIGNATURE <u>H. T. Allen</u>		M. D. <u>62 Cathedral St Annapolis, Md</u>		ADDRESS (Street, city, town, state)		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>6-16-55</u>		NAME OF CEMETERY OR CREMATORY <u>DAVIDSONVILLE</u>		LOCATION (City, town, or county) (State) <u>DAVIDSONVILLE, MD</u>	
24. REC'D BY REGISTRAR <u>June 15, 1955</u>		REGISTRAR'S SIGNATURE <u>Wm. G. French</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u>		ADDRESS <u>108 W. WASH. ST ANNA POLIS, MD</u>	



# CERTIFICATE OF DEATH

Form No. 1

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. SIGNATURE OF DECEASED

10. SIGNATURE OF WITNESS

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF CLERK

13. SIGNATURE OF JURY

14. SIGNATURE OF JUDGE

15. SIGNATURE OF SHERIFF

16. SIGNATURE OF CORONER

17. SIGNATURE OF DISTRICT ATTORNEY

18. SIGNATURE OF COUNTY CLERK

19. SIGNATURE OF TOWN CLERK

20. SIGNATURE OF VOTING CLERK

21. SIGNATURE OF JURY

22. SIGNATURE OF JUDGE

23. SIGNATURE OF SHERIFF

24. SIGNATURE OF CORONER

25. SIGNATURE OF DISTRICT ATTORNEY

26. SIGNATURE OF COUNTY CLERK

27. SIGNATURE OF TOWN CLERK

28. SIGNATURE OF VOTING CLERK

29. SIGNATURE OF JURY

30. SIGNATURE OF JUDGE

31. SIGNATURE OF SHERIFF

32. SIGNATURE OF CORONER

33. SIGNATURE OF DISTRICT ATTORNEY

34. SIGNATURE OF COUNTY CLERK

35. SIGNATURE OF TOWN CLERK

36. SIGNATURE OF VOTING CLERK

37. SIGNATURE OF JURY

38. SIGNATURE OF JUDGE

39. SIGNATURE OF SHERIFF

40. SIGNATURE OF CORONER

41. SIGNATURE OF DISTRICT ATTORNEY

42. SIGNATURE OF COUNTY CLERK

43. SIGNATURE OF TOWN CLERK

44. SIGNATURE OF VOTING CLERK

45. SIGNATURE OF JURY

46. SIGNATURE OF JUDGE

47. SIGNATURE OF SHERIFF

48. SIGNATURE OF CORONER

49. SIGNATURE OF DISTRICT ATTORNEY

50. SIGNATURE OF COUNTY CLERK

51. SIGNATURE OF TOWN CLERK

52. SIGNATURE OF VOTING CLERK

53. SIGNATURE OF JURY

54. SIGNATURE OF JUDGE

55. SIGNATURE OF SHERIFF

56. SIGNATURE OF CORONER

57. SIGNATURE OF DISTRICT ATTORNEY

58. SIGNATURE OF COUNTY CLERK

59. SIGNATURE OF TOWN CLERK

60. SIGNATURE OF VOTING CLERK

BUREAU V. S.

JUN 15 1955

RECEIVED



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05239

5245

## CERTIFICATE OF DEATH

Reg. Dist. No. 22

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>AnneArundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>AnneArundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Severn</u>		<u>33 yrs</u>		TOWN <u>Severn</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Quarterfield Road</u>				STREET ADDRESS (If rural give location) <u>Quarterfield Road</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Louisa</u> <u>Deichgraber</u>				<u>June 27</u> 19 <u>55</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<u>Female</u>	<u>White</u>	<u>Widow</u>	<u>June 29, 1861</u>	<u>93</u> yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>
<u>Housework (ret)</u>			<u>own home</u>		<u>Germany</u>		<u>Germany</u>
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Schonig</u>				<u>Unknown</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>No</u>		<u>None</u>		<u>BERTHA DEICHGRABER SEVERN, MD</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<u>450.1</u> IMMEDIATE CAUSE (A) <u>Acute Cerebral Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized arteriosclerosis and</u>				<u>1 year</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Gangrenous Arteritis.</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>				<u>Semibut incident to old age</u>			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b>			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>June 1-55</u>, 19<u>55</u> to <u>June 27-55</u>, 19<u>55</u>, that I last saw the deceased alive on <u>June 24-55</u>, 19<u>55</u>, and that death occurred at <u>9:30</u> M., from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>DATE SIGNED</b>			
<u>Joseph R. Roberts</u> M.D.				<u>6-29-55</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>Burial</u>		<u>June 29/55</u>		<u>Deichgraber Family Cem</u>		<u>Quarterfield Rd, Severn, Md</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>June 31-55</u>		<u>Richard A. Casper</u>		<u>W. J. Singleton</u>		<u>Glen Burnie, Md.</u>	

100-200

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

# CERTIFICATE OF DEATH

100-200

1. NAME OF DECEASED

2. SEX AND AGE

3. RACE

4. PLACE OF BIRTH

5. DATE OF DEATH

6. CAUSE OF DEATH

7. PLACE OF DEATH

8. SIGNATURE OF PHYSICIAN

9. SIGNATURE OF REGISTRAR

10. SIGNATURE OF WITNESS

11. SIGNATURE OF DECEASED

12. SIGNATURE OF DECEASED

BUREAU Y. S.

JUL 8 1955

RECEIVED

NOTARIAL

NOTARIAL CERTIFICATE  
I, the undersigned, a Notary Public for the State of Maryland, do hereby certify that the foregoing is a true and correct copy of the original as the same appears in the records of the State Department of Health, Baltimore, Maryland, and that the same is a true and correct copy of the original as the same appears in the records of the State Department of Health, Baltimore, Maryland.

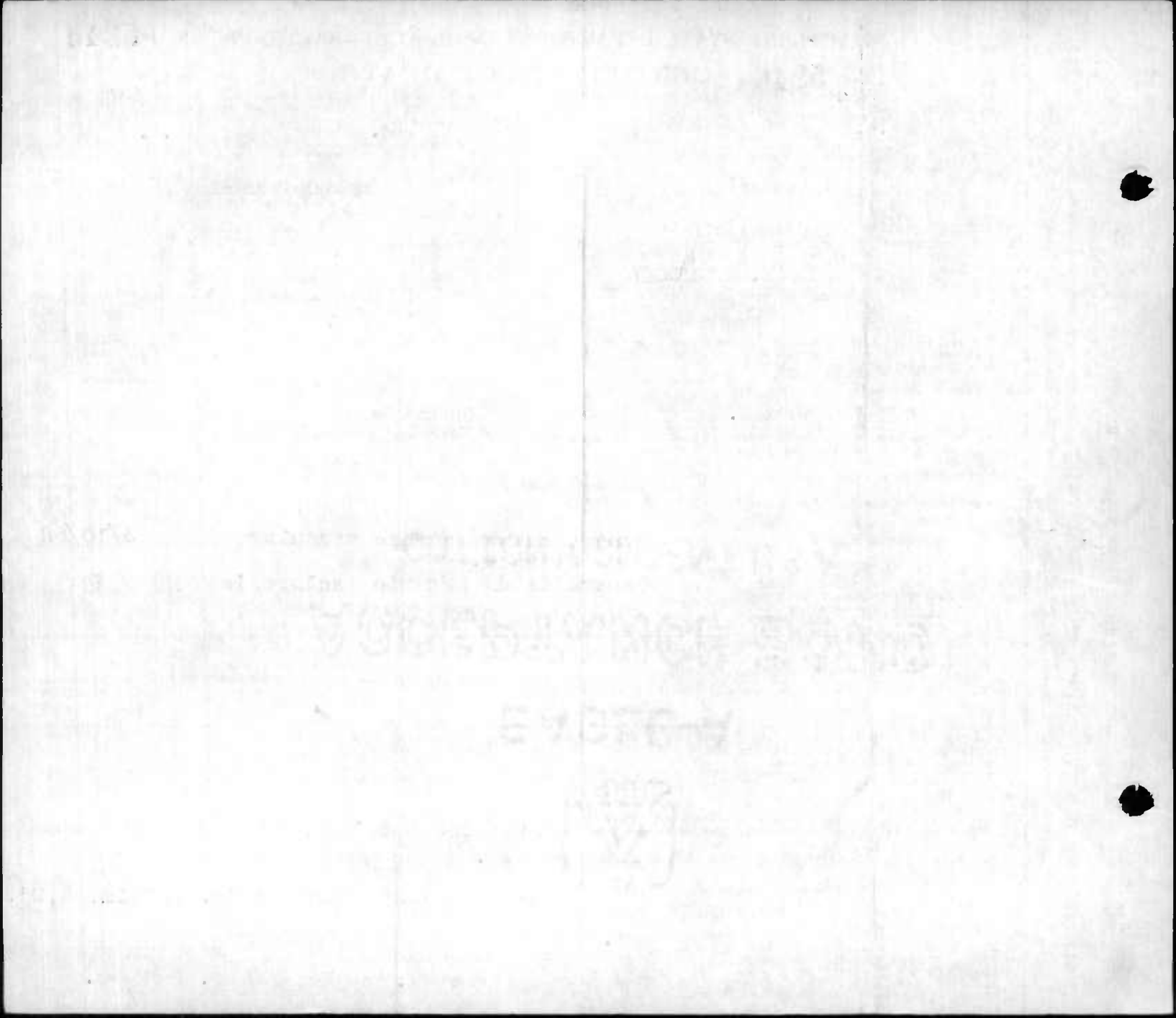
5246 CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH: COUNTY <u>A.A.</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>English Counsel</u> TOWN <u>English Counsel</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4000 Annapolis Road</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md.</u> COUNTY <u>A.A.</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>English Counsel</u> STREET ADDRESS (If rural give location) <u>4000 Annapolis Road</u>	
3. NAME OF DECEASED: (Type or Print) <u>IDA R. DIERINGER</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>6/14</u> 19 <u>55</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M</u>	8. DATE OF BIRTH: <u>10/29/87</u>
9. AGE last birthday: <u>67</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housework</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Home</u>	
11. BIRTHPLACE (State or foreign country): <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>John T.</u>		14. MOTHER'S MAIDEN NAME: <u>Sophia Dehn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Family - Same</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Hypertensive cardio vascular disease.</u>			<u>3/10/52</u>
ANTECEDENT CAUSE (B) <u>Generalized arterio sclerosis</u>			<u>?</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>3/10/1952</u> to <u>6/14/1955</u> , that I last saw the deceased alive on <u>6/14/55</u> , 19 <u>55</u> , and that death occurred at <u>8:30 A</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Harry Deice</u>		M. D. <u>1226 Hanover St. Baltimore, Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>B</u>		DATE THEREOF <u>6/17/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		LOCATION (City, town, or county) (State) <u>Baltimore</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6-30</u>		24. FUNERAL DIRECTOR ADDRESS <u>James L. McCully - 130 E. Fort Ave.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



5247  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05241  
 Reg. Dist. No. 28

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Anne Arundel</b>		MARYLAND		STATE <b>Maryland</b> COUNTY <b>Prince George's</b>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <b>Crownsville</b>		LENGTH OF STAY (in this place) <b>9 mos 9 days</b>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <b>Washington, D. C.</b>		<b>16X-2</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Crownsville State Hospital</b>				STREET ADDRESS (If rural, give location) <b>6590 Allentown Road, S. E.</b>			
3. NAME OF DECEASED: (Type or Print)		(First) <b>Charles</b>		(Middle) <b>H.</b>		(Last) <b>Dotson</b>	
5. SEX: <b>Male</b>		6. COLOR OR RACE: <b>Negro</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Married</b>		8. DATE OF BIRTH: <b>Unk.</b>	
9. AGE last birthday: <b>73?</b>		yrs. <b>6</b>		Month <b>9</b>		Day <b>19</b> Year <b>55</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY: <b>Janitor</b>		11. BIRTHPLACE (State or foreign country): <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME: <b>Unknown</b>				14. MOTHER'S MAIDEN NAME: <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <b>Unk.</b>		(If Yes, give war or dates of service) <b>Unk.</b>		16. SOCIAL SECURITY No.: <b>Unk.</b>		17. INFORMANT & ADDRESS: <b>Hospital Records</b>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
(a) <b>Decompensatory heart failure</b>		<b>Days</b>
Immediate cause DUE TO		
(b) <b>Cardiac Infarction</b>		<b>4 days</b>
Antecedent cause(s) DUE TO		
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		
(c) <b>Arteriosclerotic cardiovascular heart disease</b>		
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19a. DATE OF OPERATION: <b>2</b>		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
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21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>M</b>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE *[Signature]* CHIEF MEDICAL EXAMINER  
 M. D. DEPUTY MEDICAL EXAMINER *[Signature]* ASSISTANT MEDICAL EXAM. DATE SIGNED **June 14, 1955**

23. BURIAL, CREMATION, REMOVAL (Specify): <b>Burial</b>		DATE THEREOF: <b>June 13-55</b>		NAME OF CEMETERY OR CREMATORY: <b>St Thomas</b>		LOCATION (City, town, or county) (State): <b>Agawam Md</b>	
DATE REC'D BY LOCAL REG: <b>June 14, 1955</b>		REGISTRAR'S SIGNATURE: <i>[Signature]</i>		24. FUNERAL DIRECTOR: <b>Hunt &amp; Ryan Funeral Home</b>		ADDRESS: <b>Waldorf Md</b>	

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 15 1955

RECEIVED



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5248

## CERTIFICATE OF DEATH

05242

Reg. Dist. No. ....

Items 11, 13, 14

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Anne Arundel</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>A.A</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Davidsonville</i>				TOWN <i>Davidsonville</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>Joseph</i> (Middle) <i>Franklin</i> (Last) <i>DOVE</i>				(Month) <i>June</i> (Day) <i>5</i> (Year) <i>19 55</i>			
5. SEX <i>m</i>	6. COLOR OR RACE <i>wh.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>m</i>	8. DATE OF BIRTH <i>Jan. 31, 1884</i>	9. AGE last birthday <i>71</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <i>farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Cheney, Maryland</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Joseph Dove</i>				14. MOTHER'S MAIDEN NAME <i>Mary Powers (Powers)</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
155X IMMEDIATE CAUSE (A) <i>generalized carcinomatosis</i>						7 mos.	
ANTECEDENT CAUSE(S) DUE TO (B) <i>carcinoma of common and cystic duct</i>						6 mos.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <i>9/22/54</i>		19b. MAJOR FINDINGS OF OPERATION <i>carcinoma of cystic and common duct c metastasis</i>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Sept. 13, 1954</i> , to <i>June 5, 1955</i> , that I last saw the deceased alive on <i>6/4/55</i> , 19 <i>55</i> , and that death occurred at <i>6:30 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>S Bornach</i>				ADDRESS (Street, city, town, state) <i>Amos Garrett Blvd, Annapolis, Md.</i>		DATE SIGNED <i>6/6/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>		DATE THEREOF <i>6/8/55</i>		NAME OF CEMETERY OR CREMATORY <i>Christ Church</i>		LOCATION (City, town, or county) <i>Davidsonville</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Carrie Smith</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>F.A. Hardy 1 Son</i>		ADDRESS	
DATE <i>June 11, 1955</i>							

2401300722M

RECEIVED  
JUN 15 1955  
BUREAU V. S.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

Reg. Dist. No.

1. Name and place (house or hospital)

2. Date

3. Time

4. Cause

5. Manner

6. Age

7. Sex

8. Race

9. Occupation

10. Education

11. Marital status

12. Usual residence

13. Usual occupation

14. Usual residence

15. Usual occupation

16. Usual residence

17. Usual occupation

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99. Usual occupation

100. Usual residence

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05243

5249

## CERTIFICATE OF DEATH

Reg. Dist. No. 22

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>AA</b>		MARYLAND		STATE <b>Md.</b>		COUNTY <b>AA</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>X</b> TOWN <b>Severn (Rural)</b>		LENGTH OF STAY (in this place) <b>1 week</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Severn (Rural), Md.</b>		<b>X</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>00</b>				STREET ADDRESS (If rural give location) <b>Crain Highway</b>		<b>1</b>	
<b>3. NAME OF DECEASED</b> (Type or Print) <b>Herman Felber</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>June 12, 1955</b>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>W</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Married</b>		<b>8. DATE OF BIRTH</b> <b>Jan. 17, 1887</b>	
<b>9. AGE last birthday</b> <b>68</b> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Barber</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Hazleton, Pa.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Emil Felber</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Marie Gebhardt</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>218 - 32- 1344</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mrs Anna Felber, Crain Highway, Severn, Md.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>420.1</b> IMMEDIATE CAUSE (A) <b>Coronary Thrombosis</b>						<b>8 days.</b>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from June 3, 1955, to June 11, 1955, that I last saw the deceased alive on June 11, 1955, and that death occurred at 4:30 A.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>C. Milton Luthier</i>				<b>ADDRESS</b> (Street, city, town, state) <b>Highgate Rd</b>			
<b>DATE</b> <b>June 14, 1955</b>				<b>DATE SIGNED</b> <b>6-13-55</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>6/15/55</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Meadowridge</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Howard County, Md.</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Clara Hachup</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>James S. Kirkley</i>			
<b>DATE</b> <b>June 14, 1955</b>		<b>ADDRESS</b> <b>Hopping and Kirkley, Glen Burnie, Md.</b>					

# CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. PLACE OF BIRTH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEAREST RELATIVE

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF CHURCH OFFICIAL

17. SIGNATURE OF MINISTER

18. SIGNATURE OF CLERGYMAN

19. SIGNATURE OF RABBI

20. SIGNATURE OF OTHER

21. SIGNATURE OF OTHER

22. SIGNATURE OF OTHER

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BUREAU V. S.

JUN 17

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05244

5250

## CERTIFICATE OF DEATH

Reg. Dist. No. 22

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <i>Prince Georges</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Prince Georges</i>
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN <i>Leesburg</i>	LENGTH OF STAY (in this place) <i>2 yrs 3 mo</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Leesburg</i>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00</i>		STREET ADDRESS (If rural give location) <i>1</i>	
<b>3. NAME OF DECEASED</b> (Type or Print)		<b>4. DATE OF DEATH</b>	
(First) <i>Matilda</i> (Middle) <i>Ada</i> (Last) <i>Fittro</i>		(Month) <i>6</i> (Day) <i>24</i> (Year) <i>19 55</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE/MARRIED, WIDOWED, DIVORCED, <i>W</i>	8. DATE OF BIRTH <i>Oct 20-1882</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>	9. AGE last birthday <i>72</i> yrs.
11. BIRTHPLACE (State or foreign country) <i>Delaware Penn</i>		12. CITIZEN OF WHAT COUNTRY <i>US</i>	
13. FATHER'S NAME <i>Burton</i>		14. MOTHER'S MAIDEN NAME <i>Lidia Harris</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>3</i>	
17. INFORMANT & ADDRESS <i>Mrs Parker 2 Saville Road Md</i>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>		<b>18. MEDICAL CERTIFICATION</b>	
443X IMMEDIATE CAUSE (A) <i>Cerebral Hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Hypertensive Cardio Vascular Dis</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from Nov 6, 19 53, to June 24, 19 55, that I last saw the deceased alive on June 21, 19 55, and that death occurred at 5 P.M. from the causes and on the date stated above.</b>			
SIGNATURE <i>CR MacDonell M.D.</i>		ADDRESS (Street, city, town, state) <i>Ellen Burpee Md 6-24-55</i>	
DATE SIGNED <i>June 27-55</i>		DATE SIGNED <i>6-24-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		24. RECORD BY REGISTRAR <i>Clara Zachary</i>	
25. FUNERAL DIRECTOR'S SIGNATURE <i>William H. ...</i>		26. ADDRESS <i>Leesburg, Penn.</i>	
DATE <i>June 28, 1953</i>			



# 5280 CERTIFICATE OF DEATH

THE DEPT. OF

U.S. NAVY HOSPITAL FOR THE DEPT. OF HEALTH

U.S. NAVY HOSPITAL FOR THE DEPT. OF HEALTH

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BUREAU V. A.

JUN 29 1955

RECEIVED

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 5251 CERTIFICATE OF DEATH

05245

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Crownsville</u>				TOWN <u>Easton</u>		2040-2	
10 HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>Unknown</u>			
3. NAME OF DECEASED (Type or Print)		(First) <u>May</u>		(Middle) <u>Emma</u>		(Last) <u>Foreman</u>	
				4. DATE OF DEATH		(Month) <u>6</u> (Day) <u>9</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>3/5/38</u>	9. AGE last birthday <u>17</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months <u>-</u> Days <u>-</u>		Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - - -</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Rosie Foreman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
351 X IMMEDIATE CAUSE (A) <u>Status epilepticus</u>						<u>2 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Epilepsy</u>						<u>life</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>congenital double hemiplegia</u>						<u>life</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Idiocy</u>						<u>life</u>	
19a. DATE OF OPERATION <u>- - - -</u>		19b. MAJOR FINDINGS OF OPERATION <u>- - - -</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.) <u>- - - -</u>		21c. WHERE DID INJURY OCCUR? (City or town) <u>- - - -</u> (County) <u>- - - -</u> (State) <u>- - - -</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>- - - -</u> M. <u>-</u>		21e. INJURY OCCURRED While <input type="checkbox"/> et work <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>- - - -</u>			
22. I hereby certify that I attended the deceased from <u>6/7</u> , 19 <u>55</u> , to <u>6/9</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6/9</u> , 19 <u>55</u> , and that death occurred at <u>10 p.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>Harold Heid Reinmann</u>		ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>6/10/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>university medical</u>		DATE THEREOF <u>6/15/55</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore Md.</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
24. REC'D BY REGISTRAR <u>R.M. Joyce</u>		REGISTRAR'S SIGNATURE <u>Mrs. Frances A. Hemley</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>575 W. 1st St. Baltimore</u>			
DATE <u>6-15-55</u>							

# CERTIFICATE OF DEATH

Ref. Div. 20

1. NAME OF DECEASED (Last, first, middle)

2. SEX (Male or Female)

3. AGE (Years, months, days)

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. SIGNATURE OF DECEASED

10. SIGNATURE OF WITNESSES

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF CORONER

BUREAU V. S.

JUN 17 1955

RECEIVED

13. SIGNATURE OF REGISTRAR

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05246

5215

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>A.A.C.</i>		MARYLAND		STATE <i>MD</i>		COUNTY <i>A.A.C.</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10. TOWN <i>Annapolis</i>				TOWN <i>ANNAPOLIS</i>		10	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
90. <i>Hammond Convalescent Home</i>				2019 WEST ST. 1			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<i>EDWARD C. HABERSANK</i>				<i>6 - 23 19 55</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>Male</i>	<i>White</i>	<i>Married</i>	<i>1-28-1888</i>	<i>67</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if seasonal)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<i>Creamman &amp; C.</i>				<i>Paints &amp; Oil</i>		<i>Reading Pa.</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>Charles H. HABERSANK</i>				<i>KATE HIGH</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<i>9</i>						<i>Helen R. Habersank (2)</i>	
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <i>Coronary Occlusion</i>						<i>1/2 hr.</i>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE						<i>unknown</i>	
STATING UNDERLYING CAUSE LAST. DUE TO							
(C) <i>Generalized Arteriosclerosis</i>						<i>unknown</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>May</i> , 1955, to <i>23 June</i> , 1955, that I last saw the deceased alive on <i>23 June</i> , 1955, and that death occurred at <i>7:30 P.M.</i> from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)				DATE SIGNED	
<i>Edward A. Beal</i>		<i>46 Southgate Ave Annapolis</i>				<i>6/25/55</i>	
M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>6-26-55</i>		<i>Hill Crest Cemt</i>		<i>Annapolis Md</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>June 27, 1955</i>		<i>J. J. Ormick</i>		<i>John M. Taylor</i>		<i>508 Annapolis</i>	

2218 - CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - CHICAGO

NAME OF DECEASED  
AGE  
SEX  
RACE  
DATE OF BIRTH  
DATE OF DEATH

PLACE OF BIRTH  
CITY  
STATE  
COUNTRY

DATE OF DEATH

CAUSE OF DEATH

DECEASED AT RESIDENCE

BUREAU V. S.

JUN 28 1955

RECEIVED

5216

MARYLAND STATE DEPARTMENT OF HEALTH

05247

# CERTIFICATE OF DEATH FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH- COUNTY <u>A. A.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> TOWN <u>Annapolis</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. A. General</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>A. A.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> TOWN <u>Annapolis</u> STREET ADDRESS (If rural, give location) <u>1111 Tyler Ave</u>	
3. NAME OF DECEASED (Type or Print) <u>Margaret M. HALL</u>		4. DATE OF DEATH (Month) <u>6</u> (Day) <u>3</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>1-24-1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE last birthday <u>67</u> yrs. <u>11</u> under 1 year <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Krauer</u>		14. MOTHER'S MAIDEN NAME <u>Anne Spenner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Linwood Hall</u>		(2)	

## 18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>434.3</u> Immediate cause (a) <u>Serif disease</u> Antecedent cause(s) (b) <u>Diseases nr conditins, if any, giving rise to the above cause stating the underlying cause last</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>6-5-55</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REBURYAL, (Specify)	DATE THEREOF <u>6-5-55</u>	NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u>	LOCATION (City, town, or county) <u>Annapolis Md.</u>
DATE REC'D BY LOCAL REG. <u>June 5, 1955</u>	REGISTRAR'S SIGNATURE <u>J. J. French</u>	24. FUNERAL DIRECTOR <u>John M. Taylor Sons</u>	ADDRESS <u>Annapolis Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 7 1955

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5252

## CERTIFICATE OF DEATH

05248

Reg. Dist. No. 20

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>aa</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>McKendree</u>		<u>4 mo</u>		TOWN <u>McKendree</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS (If rural give location) <u>1</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>Margaret Matilda Hall</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>June 21 1955</u>			
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>C</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>S</u>	<b>8. DATE OF BIRTH</b> <u>Feb 5 1955</u>	<b>9. AGE last birthday</b> <u>4 MO</u> yrs.	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
				Months		Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Jewell md</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <u>John Ledlow Hall</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Charlotte JACKS</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>9</u>		<b>16. SOCIAL SECURITY NO.</b> <u>—</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>John Hall, Bristol P.O. Md</u>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<b>491X IMMEDIATE CAUSE</b> (A) <u>Bronchial Pneumonia</u>						<u>2 days</u>	
<b>ANTECEDENT CAUSE(S)</b> DUE TO							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> DUE TO							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Secondary Anemia</u>							
<b>19a. DATE OF OPERATION</b> <u>no</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21e. INJURY OCCURRED</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>June 20, 1955</u> <b>to</b> <u>June 21, 1955</u> <b>that I last saw the deceased alive on</b> <u>June 20, 1955</u> <b>and that death occurred at</b> <u>1:35</u> <b>M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>James B. Harcor</u> M.D.				<b>ADDRESS</b> (Street, city, town, state) <u>Upper Marlboro Md</u>		<b>DATE SIGNED</b> <u>6-23-55</u>	
<b>23. MANNER, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>6/24/55</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Union Chapel</u>		<b>LOCATION</b> (City, town, or county) (State) <u>McKendree Md</u>	
<b>24. REC'D BY REGISTRAR</b> <u>June 23, 1955</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Elisabeth Williams</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Bernard Harnduty</u>		<b>ADDRESS</b>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH  
**5217**  
**CERTIFICATE OF DEATH**  
**FOR MEDICAL EXAMINERS**

05249

Reg. Dist. No. 21

1. PLACE OF DEATH - COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Fred.</u>	
10. CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Brunswick</u> 10352	
11. HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Lock Haven</u> <u>DA ANN ARUNDEL</u> <u>CENTRAL HOSPITAL</u>		STREET ADDRESS (If rural give location) <u>✓</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>EARL</u> (Middle) <u>THOMAS</u> (Last) <u>HARPER</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>29</u> (Year) <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>single</u>	8. DATE OF BIRTH <u>April 7, 1947</u>
9. AGE last birthday <u>8</u> yrs.		If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Trade School</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Earl Harper</u>		14. MOTHER'S MAIDEN NAME <u>Irene Thompson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>✓</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Earl Harper - same as # 2</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
929.8 Immediate cause (a) <u>Drowning</u>			<u>✓</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., or INJURY <u>Lock Haven</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>6</u> <u>29</u> <u>55</u> <u>P</u> m.		INJURY OCCURRED While at work <input type="checkbox"/> Nt while at work <input checked="" type="checkbox"/>	
HOW DID INJURY OCCUR? <u>while swimming</u>			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>Dr. J. Daniel</u>		DATE SIGNED <u>6/29/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Removal</u>		DATE THEREOF <u>June 30, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		LOCATION (City, town, or county) (State) <u>LOVETTSVILLE, VIRGINIA</u>	
DATE REC'D BY LOCAL REG. <u>June 30, 1955</u>		24. FUNERAL DIRECTOR <u>Ben E. Hopping and Son, Annapolis, Md.</u>	

RECEIVED

JUL 1 1955

BUREAU V. S.

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5218

## CERTIFICATE OF DEATH

05250

Reg. Dist. No. 21

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>aa</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>aa</i>	
CITY (If outside corporate limits, write RURAL or end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10 TOWN <i>annapolis</i>		<i>2 days</i>		TOWN <i>Galesville</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
13 NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<i>ANNIE VIRGINIA HARRIS</i>				<i>June 9 1955</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>F</i>	<i>col.</i>	<i>married</i>	<i>April 1910</i>	<i>45</i>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Oyster Shucker</i>		<i>Sea Food</i>		<i>Galesville</i>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>William Sanders</i>				<i>Hattie Foote Sanders</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
		<i>213-05-0084</i>		<i>Joseph Harris, Galesville</i>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
<i>443X Pulmonary Edema</i>						<i>18 hr.</i>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <i>6/8/55</i> , 19 <i>55</i> , to <i>6/9</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>6/9</i> , 19 <i>55</i> , and that death occurred at <i>10:00 A.M.</i> from the causes and on the date stated above.							
SIGNATURE		M.D.		ADDRESS (Street, city, town, state)		DATE SIGNED	
<i>Theodore H. Johnson</i>				<i>37 Calvert Street Annapolis, Md</i>		<i>6/9/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
<i>Burial</i>	<i>6/14/55</i>	<i>Ebenezer</i>		<i>Galesville Md</i>			
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS			
	<i>ff - J. Daniel</i>	<i>Bernard Harduty</i>					
DATE <i>June 14, 1955</i>							

# CERTIFICATE OF DEATH

1. PLACE OF DEATH

at home of decedent  
1000 N. E. St.  
Baltimore, Md.

2. SEX

Male

3. AGE

65 years

4. OCCUPATION

Retired

5. MARITAL STATUS

Married

6. DATE OF BIRTH

April 10, 1910

7. PLACE OF BIRTH

Baltimore, Md.

8. CAUSE OF DEATH

Heart Failure

9. MEDICAL HISTORY

None

10. SIGNATURE OF DECEASED

James H. Smith

BUREAU V. S.

JUN 14 1955

RECEIVED

James H. Smith

James H. Smith

James H. Smith

James H. Smith

STATE OF MARYLAND

1. I hereby certify that the foregoing is a true and correct copy of the original certificate of death filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the 14th day of June, 1955.



1

INSTRUCTIONS

I

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5219

## CERTIFICATE OF DEATH

05251

Reg. Dist. No. 21

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>ANNE ARUNDEL</u>		STATE <u>MD</u>		COUNTY <u>AA</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>ANNAPOLIS</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		MD <u>10</u>	
TOWN <u>ANNAPOLIS</u>				STREET ADDRESS (If rural give location) <u>201 MELVIN AVE.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>							
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>VIRGINIA TYLER HEISE</u>				<u>6-10-1955</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>8-15-1878</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>SOMERSET Co. MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>ROBERT E.S. TYLER</u>				14. MOTHER'S MAIDEN NAME <u>AMANDA HALL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS <u>EDWARD C. HEISE (2)</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
422.1 IMMEDIATE CAUSE (A) <u>Cardio Vascular Failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>about 2 mos</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Congestive Heart Disease</u>				<u>8 mos</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>General Arterio Sclerosis</u>				<u>Arterial 400</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 26, 1954</u> to <u>June 10, 1955</u> , that I last saw the deceased alive on <u>June 10, 1955</u> , and that death occurred at <u>10:35 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Oliver Purvis</u>				ADDRESS (Street, city, town, state) <u>M.D. 40 Franklin St. Annapolis MD</u>		DATE SIGNED <u>6/12/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6-13-55</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u>		LOCATION (City, town, or county) <u>Annapolis Md</u>	
24. REC'D BY REGISTRAR <u>June 13, 1955</u>		REGISTRAR'S SIGNATURE <u>J. O. French</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Jam M. Taylor Sons</u>		ADDRESS <u>Annapolis Md</u>	

# CERTIFICATE OF DEATH

1. Name of deceased (Print or write full name)

2. Sex  
3. Age

4. Date of death  
5. Time of death

6. Place of death (City, State, and Country)

7. Cause of death (Immediate cause)

8. Cause of death (Underlying cause)

9. Cause of death (Contributing cause)

10. Signature of attending physician

11. Signature of medical examiner

12. Signature of registrar

13. Signature of informant

14. Signature of funeral director

15. Signature of coroner

16. Signature of justice of the peace

17. Signature of health officer

18. Signature of registrar

19. Signature of informant

20. Signature of funeral director

21. Signature of coroner

22. Signature of justice of the peace

23. Signature of health officer

24. Signature of registrar

25. Signature of informant

BUREAU V. S.

JUN 14 1955

RECEIVED

STATE OF MARYLAND

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05252

5253

## CERTIFICATE OF DEATH

Reg. Dist. No. 20

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>A. A. Co.</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>A. A.</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<i>X</i> TOWN <i>Bristol</i>				TOWN <i>Bristol</i>		<i>X</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>50</i>				STREET ADDRESS (If rural give location) <i>1</i>			
<b>3. NAME OF DECEASED</b> (Type or Print) <i>Octavia</i> (First) <i>Holt</i> (Middle) <i>Holt</i> (Last)				<b>4. DATE OF DEATH</b> (Month) <i>June</i> (Day) <i>18</i> (Year) <i>1955</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Colore</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>married</i>	8. DATE OF BIRTH <i>Oct. 19 1890</i>	9. AGE last birthday <i>64</i> yrs.	IF UNDER 1 YEAR Months <i>8</i> Days		IF UNDER 24 HRS. Hours <i></i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Punkirk Calvert Co</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>John S. Johnson</i>				14. MOTHER'S MAIDEN NAME <i>Margaret Weston</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Wesley P. Holt</i>			
<b>1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
443X IMMEDIATE CAUSE (A) <i>Cerebral Vascular Accident</i>				INTERVAL BETWEEN ONSET AND DEATH <i>74 hrs</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Hypertensive CV Disease</i>				<i>unk</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, (C) <i>260X</i>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Rhaphes mollitus</i>				<i>unk</i>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify</b> that I attended the deceased from <i>14 June 1955</i> to <i>18 June 1955</i> , that I last saw the deceased alive on <i>17 June 1955</i> , and that death occurred at <i>4:59 PM</i> , from the causes and on the date stated above.							
SIGNATURE <i>R. J. Danner</i>				ADDRESS (Street, city, town, or county) <i>type Marlboro Rd</i>		DATE SIGNED <i>20 June 55</i>	
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>6/19/55</i>		NAME OF CEMETERY OR CREMATORIUM <i>Adams</i>		LOCATION (City, town, or county) (State) <i>Lothian Md</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Paul Ann Williams</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>J. B. Johnson</i>		ADDRESS <i>Annapolis</i>	
DATE <i>6/19/55</i>							

DEAD

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5220

## CERTIFICATE OF DEATH

05253

Reg. Dist. No. 21

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>A. A. Co</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>A. A. Co</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>10</u> TOWN <u>Annapolis</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Lothian, Md</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>63</u> <u>A. A. GENERAL</u>				STREET ADDRESS (If rural give location) <u>1</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>THOMAS William JONES Jr.</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>June 22</u> <u>1955</u>			
5. SFX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Oct. 8, 1905</u>	9. AGE last birthday <u>49</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>THOMAS WILLIAM JONES SR.</u>				14. MOTHER'S MAIDEN NAME <u>EVA SUNDERLAND</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Jack Jones</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
420.1 IMMEDIATE CAUSE (A) <u>coronary occlusion</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>coronary arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> el work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 22, 1955</u> , to <u>June 22, 1955</u> , that I last saw the deceased alive on <u>June 22, 1955</u> , and that death occurred at <u>6:35 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Emily H. Wilson</u>		M. D. <u>Lothian Md.</u>		ADDRESS (Street, city, town, state) <u>Lothian Md.</u>		DATE SIGNED <u>6/23/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/24/55</u>		NAME OF CEMETERY OR CREMATORY <u>SMITHVILLE</u>		LOCATION (City, town, or county) <u>DUNKIRK MD.</u>	
24. REC'D BY REGISTRAR DATE <u>6/23/55</u>		REGISTRAR'S SIGNATURE <u>Thos. J. French</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty</u>		ADDRESS <u>Stalisville Md.</u>	



RECEIVED



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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5221

## CERTIFICATE OF DEATH

05254

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>AA</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>10 ANNAPOLIS</u>		LENGTH OF STAY (in this place) <u>DOB</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>DEALE</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>63 A. A. General</u>				STREET ADDRESS (If rural give location) <u>1</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>CHARLES</u> (First) <u>KIRCHNER</u> (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) <u>6</u> (Day) <u>12</u> (Year) <u>1955</u>			
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Married</u>	<b>8. DATE OF BIRTH</b> <u>DEC. 18, 1885</u>	<b>9. AGE last birthday</b> <u>69</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u></u> Days <u></u>	<b>IF UNDER 24 HRS.</b> Hours <u></u> Min. <u></u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Home's</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Chalk Point, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <u>William Kirchner</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>ELIZABETH WALKER</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>214-16-3922</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>LOUIS KIRCHNER, Shady Side MD</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>420.1 IMMEDIATE CAUSE (A)</b> <u>Coronary occlusion - myocardial infarction</u>						<u>1 hour</u>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>Possible coronary arteriosclerosis</u>						<u>??</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (M. <input type="checkbox"/> Not while at work <input type="checkbox"/> While at work <input type="checkbox"/>				<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>June 15, 1955</u> to <u>June 15, 1955</u>, that I last saw the deceased alive on <u>June 15, 1955</u>, and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>W. H. Herdlicks</u>		<b>M. D.</b> <u>Shady Side, Maryland</u>		<b>ADDRESS</b> (Street, city, town, state)		<b>DATE SIGNED</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>6/16/55</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Woodfield</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Traskville MD</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>Wm. J. French</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Bernard Harduty, Shady Side, Md.</u>		<b>ADDRESS</b>	
<b>DATE</b> <u>June 20, 1955</u>							

CERTIFICATE OF DEATH

1955

DATE OF DEATH

12/19/55

DEATH

DEATH

W. A. Kimmel

DECEASED

IN

MA

CORPORATE HOME

LOUIS KIRKMAN R. 2/19/55

BUREAU V. S.

JUN 20 1955

RECEIVED

RECEIVED

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH

05255

5254

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

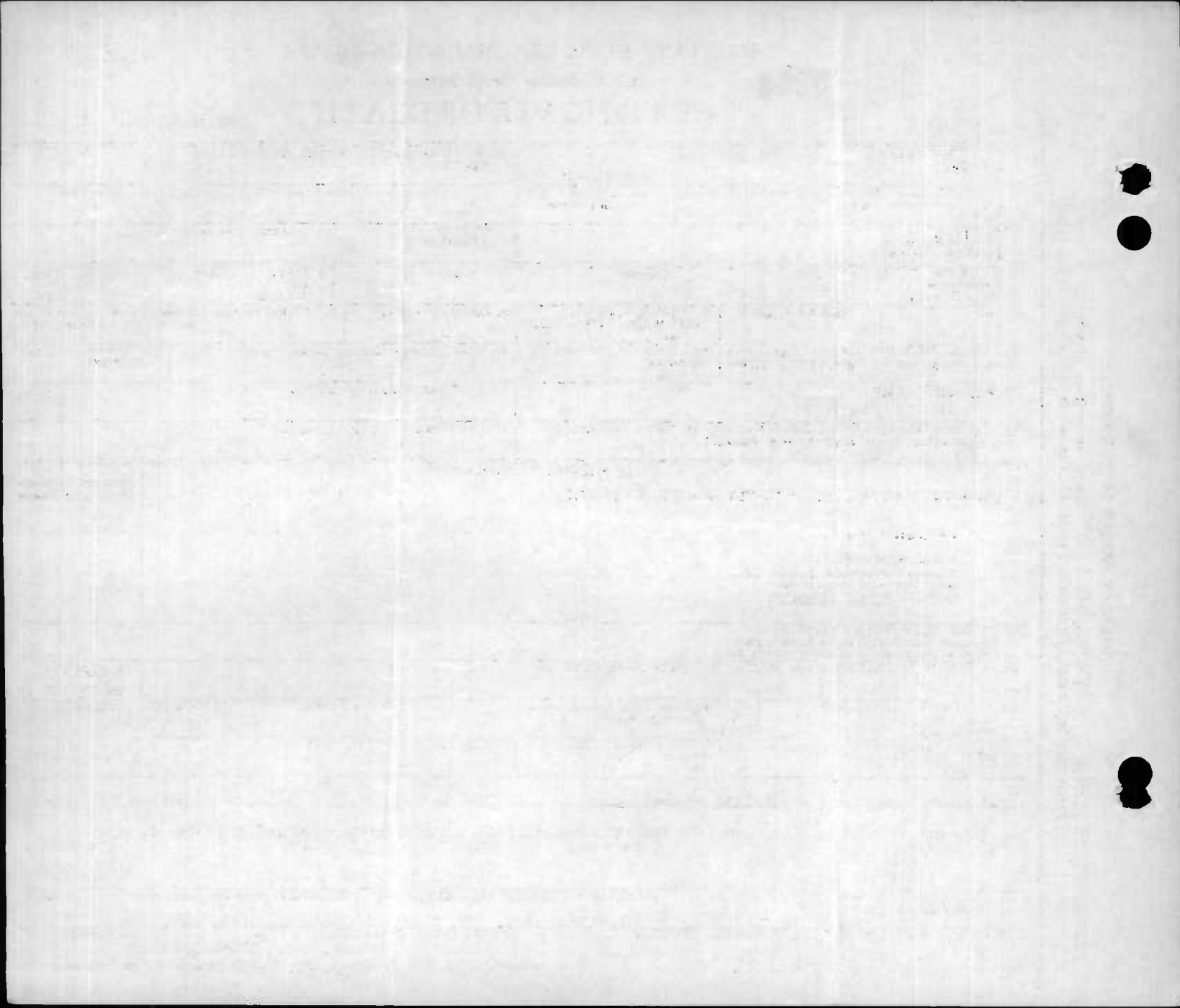
Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY Anne Arundle Co MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Clearwater Beach		CITY (If outside corporate limits, write RURAL and give nearest town) Clearwater Beach	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 8245 Parkway		STREET ADDRESS (If rural, give location) 8245 Parkway	
3. NAME OF DECEASED (Type or Print) Mrs. Anna Irene Lettau		4. DATE OF DEATH (Month) (Day) (Year) JUNE -13- 1955	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH 12-25-1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	9. AGE last birthday 64 yrs.
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Harry Tobin		14. MOTHER'S MAIDEN NAME Hatton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT AND ADDRESS Ernest Lettau, 8245 Parkway			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
4437 Immediate cause (a) Uremia			2 days
Antecedent cause(s) (b) Chronic Nephritis			2 years
(c) Hypertensive Cardiovascular disease			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Obesity			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from June 13, 1953, to 6/13/1955, that I last saw the deceased alive on 6/13/1955 and that death occurred at 6:30 p.m., from the causes and on the date stated above.			
SIGNATURE		ADDRESS	DATE SIGNED
Leanne Miller MD		1220 Cleaves St	6/14/55
23. BURIAL, CREMATION, REINTERMENT (Specify) Burial	DATE THEREOF 6-16-55	NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk. Cem.	LOCATION (City, town, or county) Glen Burnie, Md.
DATE REC'D BY LOCAL REG. 6-14-55	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR Thomas J. Kenny, Inc. 1600 Hollins St Baltimore, 23, Md.	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

## INSTRUCTIONS

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**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05256

5222

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10 TOWN <u>Annapolis</u>				TOWN <u>Annapolis</u>		10	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
63 <u>Anne Arundel General Hospital</u>				227 Wardour Drive			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) (Middle) (Last)				June 28, 1955 19			
<u>PRISCILLA STOCKWELL LYLE</u>							
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	White	Married	August 4, 1906	48 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
House wife		Own home		Philadelphia, Pa.		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Herbert G. Stockwell				Meta Melville			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
none				none		Mr. George A. Lyle- Husband- same as #2	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
153X IMMEDIATE CAUSE				INTERVAL BETWEEN ONSET AND DEATH			
(A) <u>partial intestinal obstruction with nutritional failure</u>				2 yrs. 1 mo.			
ANTECEDENT CAUSE(S) DUE TO				2 yrs. 1 mo.			
(B) <u>Recurrent Carcinoma of Colon</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				2 yrs. 8 mo.			
(C) <u>Primary Carcinoma of Sigmoid Colon</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>				2 yrs. 8 mo.			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
Sigmoid - June 18, 1955				Multiple obstructed loops with adhesions, entire bowel			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from June 3, 1955, to June 28, 1955, that I last saw the deceased alive on June 28, 1955, and that death occurred at 8:55 P.M. from the causes and on the date stated above.</b>							
SIGNATURE <u>MERTON T. WAITE</u>				ADDRESS (Street, city, town, state) <u>M.D. Cathedral &amp; Dean St. Annapolis Md.</u>			
DATE <u>June 29, 1955</u>				DATE SIGNED <u>June 29, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		July 1, 1955		St. Anne's Cemetery		Annapolis, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
June 30, 55		<u>[Signature]</u>		<u>[Signature]</u>		Hopping Funeral Home, Annapolis, Md.	



# CERTIFICATE OF DEATH

Form No. 10-1-35

1. NAME OF DECEASED

2. PLACE OF BIRTH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF FUNERAL HOME

14. SIGNATURE OF CLERGY

15. SIGNATURE OF NEAREST OF KIN

16. SIGNATURE OF OTHER

17. SIGNATURE OF

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BUREAU V. S.

JUL 1 1955

RECEIVED



1

INSTRUCTIONS

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VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5255

## CERTIFICATE OF DEATH

05257

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AnneArundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>	
CITY OR TOWN <u>Crownsville</u>		LENGTH OF STAY (in this place) <u>11 yrs. 5 mos.</u>		CITY OR TOWN <u>Baltimore City</u>		<u>3v01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Thomas</u> (Middle) <u>W.</u> (Last) <u>Matthews</u>				(Month) <u>6</u> (Day) <u>24</u> (Year) <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Sep.</u>	8. DATE OF BIRTH <u>12/2/94</u>	9. AGE last birthday <u>60</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months <u>-</u> Days <u>-</u>		Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Griffin Matthew</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Chavers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				10 months			
162X IMMEDIATE CAUSE (A) <u>Carcinoma of Lungs</u>							
ANTECEDENT CAUSE(S) DUE TO				7 months			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C) <u>Psychosis (General Paresis - arrested)</u>				Years - 11			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>2</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>1/5</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/5</u> , 19 <u>55</u> , to <u>6/24</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6/24</u> , 19 <u>55</u> , and that death occurred at <u>4:45p.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>W. J. Kelson</u> M.D.				ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>6/24/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>6-29-55</u>		DATE THEREOF <u>6/29/55</u>		NAME OF CEMETERY OR CREMATORY <u>St. John's</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Geo. J. Kelson</u>		ADDRESS <u>1348 N. Calhoun St.</u>	
DATE							

# CERTIFICATE OF DEATH

FILE NO.

LOCAL HEALTH DEPARTMENT OF BALTIMORE

<p>NAME OF DECEASED</p>		<p>DATE OF BIRTH</p>	
<p>RESIDENCE</p>		<p>DATE OF DEATH</p>	
<p>CAUSE OF DEATH</p>		<p>PLACE OF DEATH</p>	
<p>DATE OF INTERMENT</p>		<p>PLACE OF INTERMENT</p>	
<p>NAME OF FUNERAL HOME</p>		<p>NAME OF MINISTER</p>	
<p>NAME OF CLERGYMAN</p>		<p>NAME OF SURGEON</p>	
<p>NAME OF PHYSICIAN</p>		<p>NAME OF NURSE</p>	
<p>NAME OF MIDWIFE</p>		<p>NAME OF DENTIST</p>	
<p>NAME OF OPTICIAN</p>		<p>NAME OF PHARMACEUTIC</p>	
<p>NAME OF VETERINARIAN</p>		<p>NAME OF LABORER</p>	
<p>NAME OF ARTIST</p>		<p>NAME OF MUSICIAN</p>	
<p>NAME OF WRITER</p>		<p>NAME OF ACTOR</p>	
<p>NAME OF DANCER</p>		<p>NAME OF SINGER</p>	
<p>NAME OF COMPOSER</p>		<p>NAME OF DIRECTOR</p>	
<p>NAME OF PRODUCER</p>		<p>NAME OF EDITOR</p>	
<p>NAME OF PUBLISHER</p>		<p>NAME OF DISTRIBUTOR</p>	
<p>NAME OF RETAILER</p>		<p>NAME OF WHOLESALE</p>	
<p>NAME OF MANUFACTURER</p>		<p>NAME OF IMPORTER</p>	
<p>NAME OF EXPORTER</p>		<p>NAME OF SHIPPER</p>	
<p>NAME OF CARRIER</p>		<p>NAME OF FREIGHT</p>	
<p>NAME OF PASSENGER</p>		<p>NAME OF CREW</p>	
<p>NAME OF CAPTAIN</p>		<p>NAME OF FIRST OFFICER</p>	
<p>NAME OF SECOND OFFICER</p>		<p>NAME OF THIRD OFFICER</p>	
<p>NAME OF FOURTH OFFICER</p>		<p>NAME OF FIFTH OFFICER</p>	
<p>NAME OF SIXTH OFFICER</p>		<p>NAME OF SEVENTH OFFICER</p>	
<p>NAME OF EIGHTH OFFICER</p>		<p>NAME OF NINTH OFFICER</p>	
<p>NAME OF TENTH OFFICER</p>		<p>NAME OF ELEVENTH OFFICER</p>	
<p>NAME OF TWELFTH OFFICER</p>		<p>NAME OF THIRTEENTH OFFICER</p>	
<p>NAME OF FOURTEENTH OFFICER</p>		<p>NAME OF FIFTEENTH OFFICER</p>	
<p>NAME OF SIXTEENTH OFFICER</p>		<p>NAME OF SEVENTEENTH OFFICER</p>	
<p>NAME OF EIGHTEENTH OFFICER</p>		<p>NAME OF NINETEENTH OFFICER</p>	
<p>NAME OF TWENTIETH OFFICER</p>		<p>NAME OF TWENTY-FIRST OFFICER</p>	
<p>NAME OF TWENTY-SECOND OFFICER</p>		<p>NAME OF TWENTY-THIRD OFFICER</p>	
<p>NAME OF TWENTY-FOURTH OFFICER</p>		<p>NAME OF TWENTY-FIFTH OFFICER</p>	
<p>NAME OF TWENTY-SIXTH OFFICER</p>		<p>NAME OF TWENTY-SEVENTH OFFICER</p>	
<p>NAME OF TWENTY-EIGHTH OFFICER</p>		<p>NAME OF TWENTY-NINTH OFFICER</p>	
<p>NAME OF THIRTIETH OFFICER</p>		<p>NAME OF THIRTY-FIRST OFFICER</p>	
<p>NAME OF THIRTY-SECOND OFFICER</p>		<p>NAME OF THIRTY-THIRD OFFICER</p>	
<p>NAME OF THIRTY-FOURTH OFFICER</p>		<p>NAME OF THIRTY-FIFTH OFFICER</p>	
<p>NAME OF THIRTY-SIXTH OFFICER</p>		<p>NAME OF THIRTY-SEVENTH OFFICER</p>	
<p>NAME OF THIRTY-EIGHTH OFFICER</p>		<p>NAME OF THIRTY-NINTH OFFICER</p>	
<p>NAME OF FORTIETH OFFICER</p>		<p>NAME OF FORTY-FIRST OFFICER</p>	
<p>NAME OF FORTY-SECOND OFFICER</p>		<p>NAME OF FORTY-THIRD OFFICER</p>	
<p>NAME OF FORTY-FOURTH OFFICER</p>		<p>NAME OF FORTY-FIFTH OFFICER</p>	
<p>NAME OF FORTY-SIXTH OFFICER</p>		<p>NAME OF FORTY-SEVENTH OFFICER</p>	
<p>NAME OF FORTY-EIGHTH OFFICER</p>		<p>NAME OF FORTY-NINTH OFFICER</p>	
<p>NAME OF FIFTIETH OFFICER</p>		<p>NAME OF FIFTY-FIRST OFFICER</p>	
<p>NAME OF FIFTY-SECOND OFFICER</p>		<p>NAME OF FIFTY-THIRD OFFICER</p>	
<p>NAME OF FIFTY-FOURTH OFFICER</p>		<p>NAME OF FIFTY-FIFTH OFFICER</p>	
<p>NAME OF FIFTY-SIXTH OFFICER</p>		<p>NAME OF FIFTY-SEVENTH OFFICER</p>	
<p>NAME OF FIFTY-EIGHTH OFFICER</p>		<p>NAME OF FIFTY-NINTH OFFICER</p>	
<p>NAME OF SIXTIETH OFFICER</p>		<p>NAME OF SIXTY-FIRST OFFICER</p>	
<p>NAME OF SIXTY-SECOND OFFICER</p>		<p>NAME OF SIXTY-THIRD OFFICER</p>	
<p>NAME OF SIXTY-FOURTH OFFICER</p>		<p>NAME OF SIXTY-FIFTH OFFICER</p>	
<p>NAME OF SIXTY-SIXTH OFFICER</p>		<p>NAME OF SIXTY-SEVENTH OFFICER</p>	
<p>NAME OF SIXTY-EIGHTH OFFICER</p>		<p>NAME OF SIXTY-NINTH OFFICER</p>	
<p>NAME OF SEVENTIETH OFFICER</p>		<p>NAME OF SEVENTY-FIRST OFFICER</p>	
<p>NAME OF SEVENTY-SECOND OFFICER</p>		<p>NAME OF SEVENTY-THIRD OFFICER</p>	
<p>NAME OF SEVENTY-FOURTH OFFICER</p>		<p>NAME OF SEVENTY-FIFTH OFFICER</p>	
<p>NAME OF SEVENTY-SIXTH OFFICER</p>		<p>NAME OF SEVENTY-SEVENTH OFFICER</p>	
<p>NAME OF SEVENTY-EIGHTH OFFICER</p>		<p>NAME OF SEVENTY-NINTH OFFICER</p>	
<p>NAME OF EIGHTIETH OFFICER</p>		<p>NAME OF EIGHTY-FIRST OFFICER</p>	
<p>NAME OF EIGHTY-SECOND OFFICER</p>		<p>NAME OF EIGHTY-THIRD OFFICER</p>	
<p>NAME OF EIGHTY-FOURTH OFFICER</p>		<p>NAME OF EIGHTY-FIFTH OFFICER</p>	
<p>NAME OF EIGHTY-SIXTH OFFICER</p>		<p>NAME OF EIGHTY-SEVENTH OFFICER</p>	
<p>NAME OF EIGHTY-EIGHTH OFFICER</p>		<p>NAME OF EIGHTY-NINTH OFFICER</p>	
<p>NAME OF NINETYETH OFFICER</p>		<p>NAME OF NINETY-FIRST OFFICER</p>	
<p>NAME OF NINETY-SECOND OFFICER</p>		<p>NAME OF NINETY-THIRD OFFICER</p>	
<p>NAME OF NINETY-FOURTH OFFICER</p>		<p>NAME OF NINETY-FIFTH OFFICER</p>	
<p>NAME OF NINETY-SIXTH OFFICER</p>		<p>NAME OF NINETY-SEVENTH OFFICER</p>	
<p>NAME OF NINETY-EIGHTH OFFICER</p>		<p>NAME OF NINETY-NINTH OFFICER</p>	
<p>NAME OF HUNDRETH OFFICER</p>		<p>NAME OF HUNDRED-FIRST OFFICER</p>	

NOTARIAL

DEPARTMENT OF HEALTH

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5256

## CERTIFICATE OF DEATH

Reg. Dist. No. 05258

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>A.A.Co.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>A.A.Co.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR	
TOWN <u>Fennedale</u>	<u>30 years</u>	TOWN <u>Fennedale</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hamons Ferry Rd.</u>		STREET ADDRESS (If rural give location) <u>Hamons Ferry Rd.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Alfred Mitchell Meachem</u>		DATE OF DEATH: <u>6</u> <u>3</u> <u>1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>July 15, 1887</u>
9. AGE last birthday <u>67</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Stevordore</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Cherry Keo Co. S.C.</u>	
11. BIRTHPLACE (State or foreign country): <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Nelson Meachem</u>		14. MOTHER'S MAIDEN NAME: <u>Margaret ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Hamons Ferry Rd.</u>	
17. INFORMANT & ADDRESS: <u>Annie Mitchell Meachem</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Coronary Arteriosclerosis</u>		<u>2 weeks</u>	
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Arterio Sclerosis</u>		<u>unknown</u>	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>12/6/54</u> , 19....., to <u>6/3/55</u> , 19....., that I last saw the deceased alive on <u>6/3/55</u> , 19....., and that death occurred at <u>8 A</u> M, from the causes and on the date stated above.			
SIGNATURE <u>John Alexander</u>		ADDRESS <u>Hamons Ferry Rd.</u>	
DATE SIGNED <u>6/3/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/7/1955</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Rose Cem.</u>		LOCATION (City, town, or county) (State) <u>Hamons Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6-7-55</u>		REGISTRAR'S SIGNATURE <u>Dr. W. H. Adams</u>	
24. FUNERAL DIRECTOR <u>Miss Kate R. Williams</u>		ADDRESS <u>Schroeder St.</u>	

STATE OF MAHARAJA

MAHARAJA STATE DEPARTMENT OF HEALTH-BALNARHUR 12

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MAHARAJA STATE DEPARTMENT OF HEALTH-BALNARHUR 12

## 5257 CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY OR TOWN <u>Crownsville</u>		LENGTH OF STAY (in this place) <u>59 days</u>		CITY OR TOWN <u>Baltimore</u>		<u>3Y01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>931 N. Eden Street</u>			
3. NAME OF DECEASED (Type or Print) <u>Lula</u> (First) <u>Molock</u> (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>June 11, 1955</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widow</u>		8. DATE OF BIRTH <u>1/17/01</u>	
9. AGE last birthday <u>54 years</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Jones</u>				14. MOTHER'S MAIDEN NAME <u>Clay Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Hypertensive &amp; Arteriosclerotic Cardiovascular Ds.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>known to us 69 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized &amp; Cerebral Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>---</u>		19b. MAJOR FINDINGS OF OPERATION <u>---</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>---</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>---</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>---</u>			
22. I hereby certify that I attended the deceased from <u>4/13</u> , 1955, to <u>6/11</u> , 1955, that I last saw the deceased alive on <u>6/11</u> , 1955, and that death occurred at <u>7:15 a.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>6/11/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/15/55</u>		NAME OF CEMETERY OR CREMATORY <u>Int. Calvary</u>		LOCATION (City, town, or county) (State) <u>Anne Arundel Co. Md.</u>	
24. REC'D BY REGISTRAR <u>[Signature]</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>[Signature]</u>	
DATE <u>June 13, 1955</u>							

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.



2257 CERTIFICATE OF DEATH

Reg. No. 2257

1. NAME OF DECEASED

2. SEX OF DECEASED

3. DATE OF BIRTH

4. PLACE OF BIRTH

5. OCCUPATION

6. CAUSE OF DEATH

7. PLACE OF DEATH

8. TIME OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESS

12. SIGNATURE OF DECEASED

13. SIGNATURE OF DECEASED

14. SIGNATURE OF DECEASED

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BUREAU V. S.

JUN 18 1955

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **05260**  
**5258** CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Anne Arundel</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY <b>A.A.</b>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Millersville</b>	LENGTH OF STAY (in this place) <b>10 days</b>	CITY (If outside corporate limits, write RURAL and give nearest town) <b>Severn</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Sann's Nursing Home.</b>		STREET ADDRESS (If rural give location) <b>Old Quaterfield Rd.</b>	

3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE OF DEATH: (Month) (Day) (Year)		
<b>Anna Moore</b>			<b>June 17th. 1955</b>		
5. SEX: <b>F.</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Single</b>	8. DATE OF BIRTH: <b>Sept. 18 1865</b>		
			9. AGE last birthday: <b>89</b> yrs. Months Days Hours Min.		
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): <b>None.</b>		10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <b>Camden, N. J.</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: <b>Patrick Moore</b>			14. MOTHER'S MAIDEN NAME: <b>Mary Lynn</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS: <b>Mrs. Helen Danza Quarterfield Rd. Severn, Md.</b>		

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<b>450.0</b> Immediate cause (a) <b>General Arteriosclerosis</b> DUE TO		<b>?</b>
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO		
(c)		

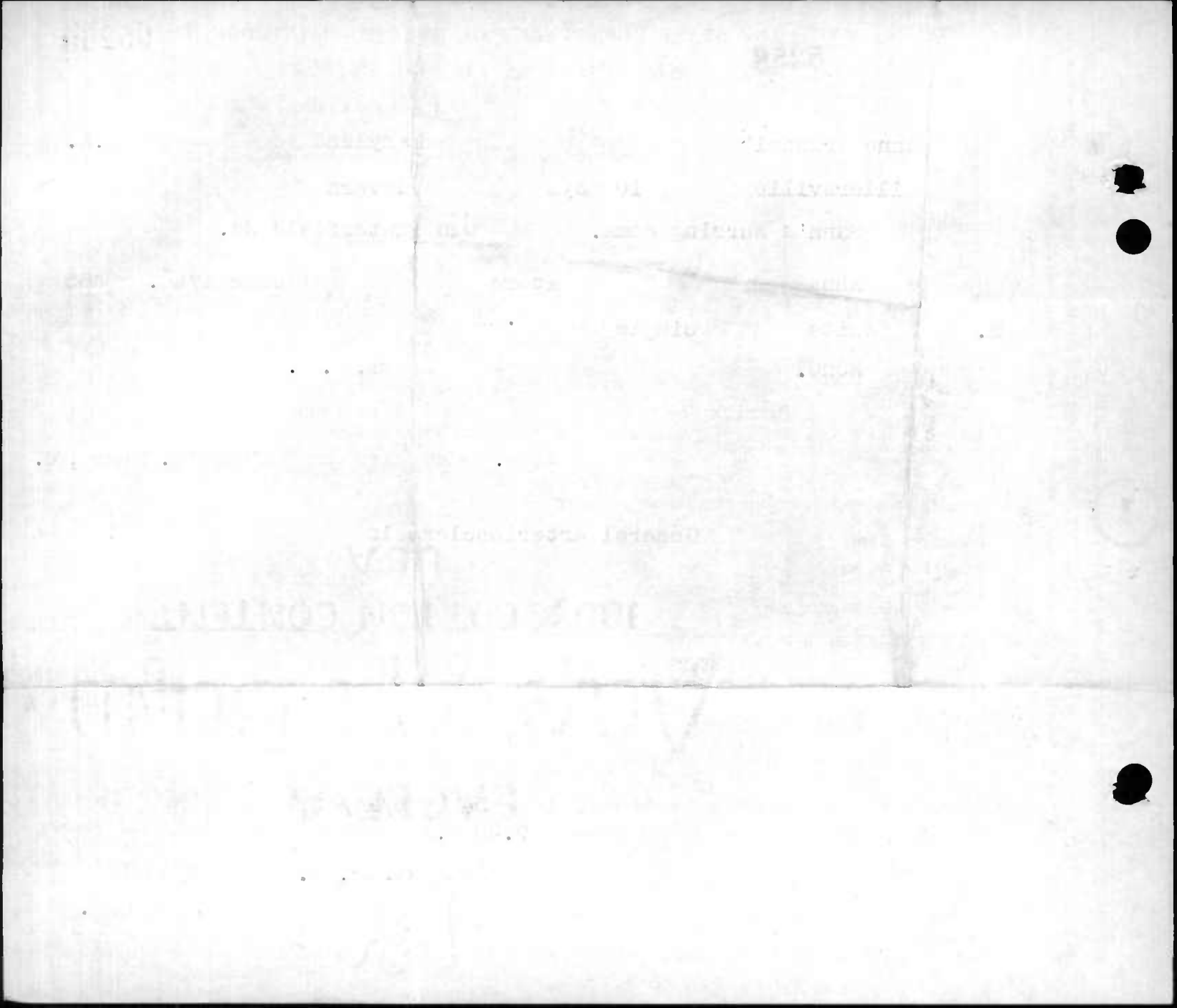
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **5/1**....., **1954**....., to **6/17/55**, 19....., that I last saw the deceased alive on **6/17/55**, 19....., and that death occurred at **9.30 A.M.** from the causes and on the date stated above.

SIGNATURE <b>Eustace B. Paulsen M.D.</b>		ADDRESS <b>Glen Burnie, Md.</b>		DATE SIGNED <b>6/17/55</b>	
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)	
<b>Burial</b>	<b>6/20/55</b>	<b>Baltimore Cemetery</b>	<b>Baltimore, Maryland.</b>		
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS		
<b>6-20-55</b>	<b>A. W. Hedrick</b>	<b>H. W. Heaton, Sr. 8057 Calvert St.</b>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5259 CERTIFICATE OF DEATH

05261

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>AA</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X</u> TOWN <u>HARWOOD</u>		LENGTH OF STAY (in this place) <u>54YRS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Harwood</u> <u>X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>DO</u>				STREET ADDRESS (If rural give location) <u>1</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>IDA</u> <u>E</u> <u>MOORE</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>June 23</u> 19 <u>55</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Aug 14 1877</u>	9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Douglasville, Alabama</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Levi Solomon</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Mayo</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>ANNIE BELL BISCHOFF, Harwood MD</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
331X IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>acidosis, diarrhea-</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>cerebral arteriosclerosis</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>June 21, 1955</u> , <b>to</b> <u>June 22, 1955</u> , <b>that I last saw the deceased alive on</b> <u>June 22, 1955</u> , <b>and that death occurred at</b> <u>10:30</u> <b>A.M.</b> <b>from the causes and on the date stated above.</b> <b>SIGNATURE</b> <u>Emily A. Mearns</u> <b>M.D.</b> <u>Lothman, Md.</u> <b>DATE SIGNED</b> <u>6/23/55</u> <b>ADDRESS</b> (Street, city, town, state) (State)							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/26/55</u>		NAME OF CEMETERY OR CREMATORY <u>Bethany</u>		LOCATION (City, town, or county) <u>Andalusia, Alabama</u>	
24. REC'D BY REGISTRAR DATE <u>6/23/55</u>		REGISTRAR'S SIGNATURE <u>Geni West Williams</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>BERNARD Horbesky Lakesville Md.</u>			

# CERTIFICATE OF DEATH

REG. DIST. NO.

TO BE FILLED BY THE REGISTRAR OF DEATHS

DATE OF DEATH

NAME OF DECEASED  
 SEX  
 AGE  
 OCCUPATION

DATE OF BIRTH  
 PLACE OF BIRTH  
 MARITAL STATUS

CAUSE OF DEATH  
 MANNER OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

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DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

BUREAU Y. 1

JUN 24 1955

RECEIVED

REMARKS

6/25/55  
 Death of ...

05262

5223

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH COUNTY <u>A. A.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD.</u> COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Deale</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>A. G. General</u>		STREET ADDRESS (If rural, give location) <u>7</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>W.</u> (Middle) <u>WEEMS</u> (Last) <u>NIHISER</u>	4. DATE OF DEATH (Month) <u>6</u> (Day) <u>3</u> (Year) <u>1955</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. <u>MARRIED</u>	8. DATE OF BIRTH <u>9-3-1888</u>
9. AGE last birthday <u>66</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, such as if retired) <u>Postmaster</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Winston M. Nihiser</u>		14. MOTHER'S MAIDEN NAME <u>Eustavia Weems</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>THOMAS A. GONDER</u>	
17. INFORMANT AND ADDRESS <u>1801 1st. NW, Washington, DC.</u>		18. MEDICAL CERTIFICATION	

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

976X  
 Immediate cause (a) Sun Shot wound Skull  
 Antecedent cause(s) (b) None  
 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY <u>Home</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>6</u> <u>2</u> <u>55</u> <u>7</u> m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Gun Shot Wound</u>		

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>6-3-1955</u>	<u>Episcopal Church Yard</u>	<u>Deale</u>	<u>MD</u>

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

June 3, 1955  
J. J. O'Donnell  
John W. Taylor Sons  
Annapolis  
MD.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 6 1955

RECEIVED



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5224

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Bill-0183 6-27-55 et

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

05263

Reg. Dist.

No. 21

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Annapolis</u>				TOWN <u>Annapolis</u>		<u>10</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>DOA Anne Arundel General</u>				STREET ADDRESS (If rural, give location) <u>321 Burnside Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>ADDIE NORFOLK</u>				<u>JUNE 17, 19 55</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>April 7, 1882</u>	
9. AGE last birthday: <u>73</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY: <u>own home</u>		11. BIRTHPLACE (State or foreign country): <u>Dunkirk, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>House wife</u>				13. FATHER'S NAME: <u>John L. BRADY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>				16. SOCIAL SECURITY No.: <u>none</u>		17. INFORMANT & ADDRESS: <u>Mr. Edward R. Norfolk, Husband-same as # 2</u>	
10b. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>House wife</u>				14. MOTHER'S MAIDEN NAME: <u>Molly ROGERS</u>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
<u>331X</u> Immediate cause (a) <u>Cerebral Hemorrhage</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause <u>DUE TO</u> stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION: <u>June 18, 1955</u>		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Home</u>		21c. (City or town) (County) (State) <u>Annapolis Anne Arundel Maryland</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>June 17, 55 p M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Natural Causes</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>Elmer G. Linhardt</u>		CHIEF MEDICAL EXAMINER <u>Elmer G. Linhardt</u> M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>June 18, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>June 20, 55</u>		NAME OF CEMETERY OR CREMATORY <u>Hillcrest Memorial Cem</u>	
DATE REC'D BY LOCAL REG. <u>June 20, 55</u>		REGISTER'S SIGNATURE <u>J. J. ...</u>		LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
		24. FUNERAL DIRECTOR <u>HOPPING FUNERAL HOME</u>		ADDRESS <u>ANNAPOLIS, MD.</u>	

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MAILED 7, 1955

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BUREAU V. S.

JUN 22 1955

RECEIVED

1955

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1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05264

5260

## CERTIFICATE OF DEATH

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Rural Edgewater</u>		<u>Unknown</u>		TOWN <u>Rural Edgewater</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mayo Road</u>				STREET ADDRESS (If rural give location) <u>Mayo Road</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Emma Maybelle Pierce</u>				<u>June 18 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>W</u>	<u>M</u>		<u>63</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Madison, Indiana</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Louis D. Wright</u>				14. MOTHER'S MAIDEN NAME <u>Ida A. Harms</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>424-22-6982</u>		17. INFORMANT & ADDRESS <u>William Pierce, Mayo Road</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
420.1 IMMEDIATE CAUSE (A) <u>Coronary artery disease</u>						<u>Unknown</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive arteriosclerotic cardiovascular disease</u>						<u>at least 6 months</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2 April 1955</u> , to <u>4 June 1955</u> , that I last saw the deceased alive on <u>4 June 1955</u> , and that death occurred at <u>4:10 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>John E. Hedeman</u>				ADDRESS (Street, city, town, state) <u>M.D. 90 Cathedral St., Annapolis, Md.</u>			
DATE <u>6/22/55</u>				DATE SIGNED			
23. BURIAL CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/14/55</u>		NAME OF CEMETERY OR CREMATORY <u>Mayo Memorial</u>		LOCATION (City, town, or county) (State) <u>Mayo Road</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Edward Collinson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Benjamin Hardisty</u>		ADDRESS <u>Galesville Md</u>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5261

## CERTIFICATE OF DEATH

05265

Reg. Dist. No.

Item 14, Film 183 7-1-55 et

## 1. PLACE OF DEATH:

COUNTY ANNE ARUNDEL MARYLAND  
CITY (If outside corporate limits, write RURAL and give nearest town) ORCHARD BEACH LENGTH OF STAY (in this place) 25 YEARS  
HOSPITAL OR INSTITUTION OR STREET ADDRESS 7812 WATERVIEW DRIVE

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY A. A.  
CITY (If outside corporate limits, write RURAL and give nearest town) ORCHARD BEACH  
STREET ADDRESS (If rural give location) 7812 Waterview Drive

## 3. NAME OF DECEASED:

(First) Lena (Middle) Mary (Last) PAUETT  
(Type or Print)

4. DATE OF DEATH: JUNE 24 19 55  
(Month) (Day) (Year)

## 5. SEX:

FEMALE  
RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOWED

## 8. DATE OF BIRTH:

JULY 9, 1878

9. AGE last birthday: 76 yrs. Months Days Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): Balt., Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

## 13. FATHER'S NAME:

Henry Meyer

## 14. MOTHER'S MAIDEN NAME:

Unknown

15 WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) NO  
(If Yes, give war or dates of service)

## 16. SOCIAL SECURITY No.:

4 NO

## 17. INFORMANT &amp; ADDRESS:

Margaret Gutter - Orchard Beach, Md.

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X  
Immediate cause

(a) Cerebral Hemorrhage  
DUE TO

Antecedent causes (s)  
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Hypertensive Cardio Vascular Disease  
DUE TO

(c) Arteriosclerotic Cardio Vascular Disease

Interval Between Onset And Death

3 days

10 years

10 years

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

0

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY ?

Yes ☐ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)  
OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from 1946 to 6/24, 19 55, that I last saw the deceased

alive on 6/22, 19 55, and that death occurred at 3:00 AM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE/SIGNED

## 23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF 6/27/55

NAME OF CEMETERY OR CREMATORY Meadowridge

LOCATION (City, town, or county) Baltimore

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

ADDRESS

6-27-55 A.W. Hedrick  
Dup

James L. McCully - 130 E. Fort Ave.

1277



5262

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

05266

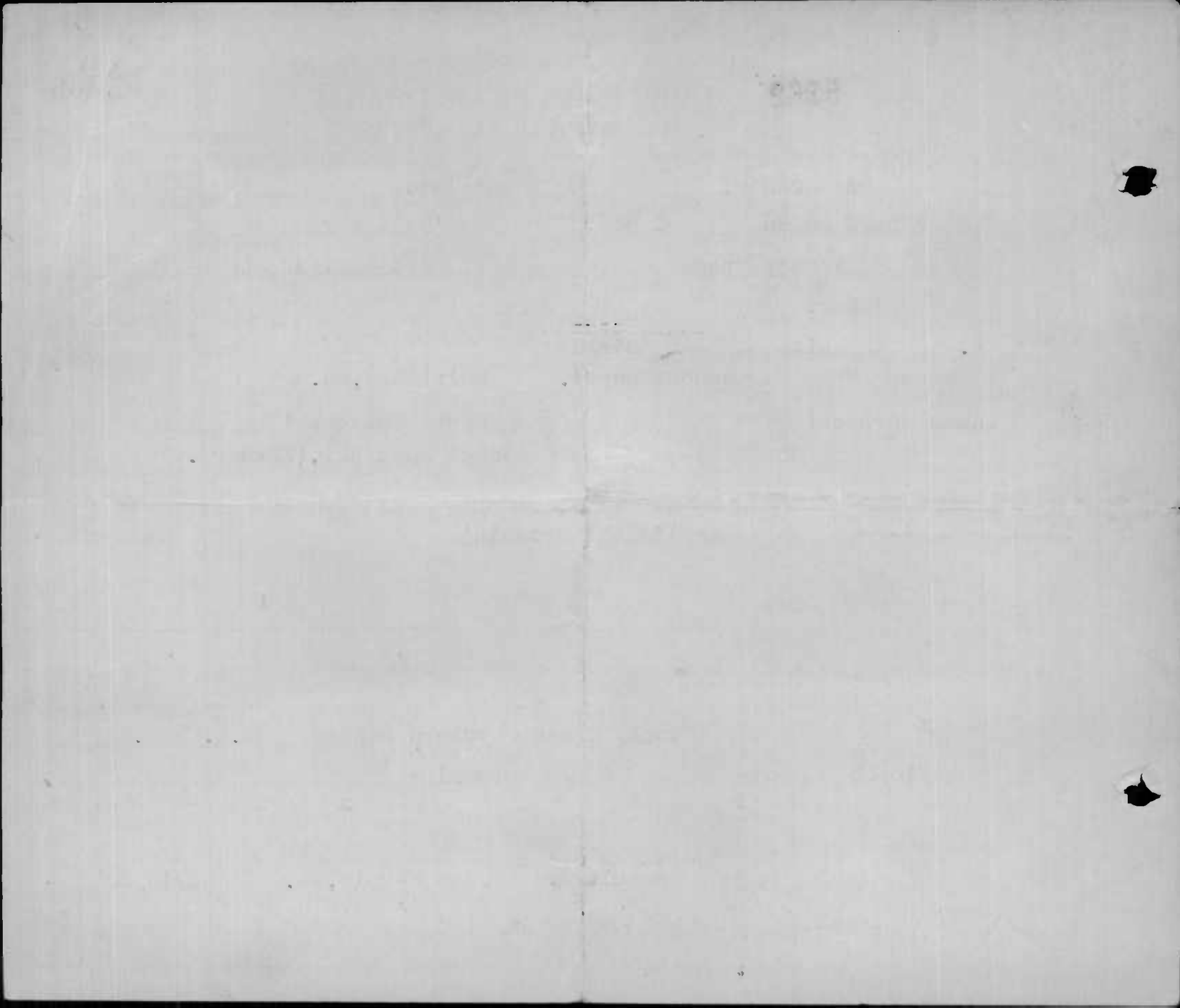
Reg. Dist. No. ....

1. PLACE OF DEATH - COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <b>Maryland</b>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <b>Orchard Beach</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
TOWN <b>Orchard Beach</b>		TOWN <b>Baltimore</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Stoney Creek</b>		STREET ADDRESS (If rural, give location) <b>2414 Fleet Street</b>	
3. NAME OF DECEASED (First) <b>Robert</b>	(Middle) <b>ROMAULD</b>	(Last) <b>Sarnecki</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>6/16/55</b>
5. SEX <b>M.</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Single</b>	8. DATE OF BIRTH <b>Nov 23, 1938</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School pupil.</b>	9. AGE last birthday <b>16</b> yrs.
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b></b>	
13. FATHER'S NAME <b>James Sarnecki</b>		14. MOTHER'S MAIDEN NAME <b>Marie Kotkowski</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-26-8175</b>	
17. INFORMANT AND ADDRESS <b>James Sarnecki, (father).</b>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>929.8</b>		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <b>Accidental Drowning</b>		<b>Sudden</b>	
Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <b>6/16/55</b>		19b. MAJOR FINDINGS OF OPERATION <b>Drowning</b>	
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>Orchard Beach</b>	
TIME (Month) (Day) (Year) (Hour) <b>6/16/55 Noon m.</b>		(CITY OR TOWN) (COUNTY) (STATE) <b>Orchard Beach A.A. Md.</b>	
INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR? <b>Drowning</b>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE <b>Custard P. Paulk</b>		ADDRESS <b>Glen Burnie, Md.</b>	
DEGREE OR TITLE <b>Deputy Medical Examiner,</b>		DATE SIGNED <b>6/16/55</b>	
23. BURIAL, CREMATION OR REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>6/20/55</b>	
NAME OF CEMETERY OR CREMATORY <b>St. Mary's</b>		LOCATION (City, town, or county) (State) <b>1300 S. D. Md.</b>	
DATE REC'D BY LOCAL REG. <b>6-17-55</b>		24. FUNERAL DIRECTOR <b>George A. Weber</b>	
REGISTRAR'S SIGNATURE <b>St. Mary's</b>		ADDRESS <b>705 S. D. Md.</b>	

MARGIN RESERVE FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5263

## CERTIFICATE OF DEATH

05267

Reg. Dist. No. 20

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>AA</u>	
CITY OR TOWN <u>Turkey Pt.</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>Turkey Pt.</u>		(If outside corporate limits, write RURAL and give nearest town)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Charles</u> (Middle) <u>A.</u> (Last) <u>Schofield</u>				(Month) <u>6</u> (Day) <u>27</u> (Year) <u>1955</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH <u>11-24-1877</u>	9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Elevator Operator</u>		11. BIRTHPLACE (State or foreign country) <u>Barnsville Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William P. Schofield</u>				14. MOTHER'S MAIDEN NAME <u>Anna Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Elsie M. Schofield</u> (2)			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
420.1 IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>				5 min			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/27/55</u> , 19 <u>55</u> , to <u>4/29/55</u> , that I last saw the deceased alive on <u>4/27/55</u> , 19 <u>55</u> , and that death occurred at <u>12:15 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Frank M. Shipley</u>				DATE SIGNED <u>4/28/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>6-28-55</u>		NAME OF CEMETERY OR CREMATORY <u>Lakewood Memorial Park</u>		LOCATION (City, town, or county) <u>Pittsburg Pa</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Edward Hollison</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>		ADDRESS <u>Union, Maryland</u>	
DATE <u>4/29/55</u>							

# CERTIFICATE OF DEATH

Page Two

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX  
4. AGE  
5. DATE OF BIRTH  
6. PLACE OF BIRTH

7. RACE

8. SEX

9. AGE

10. DATE OF BIRTH

11. PLACE OF BIRTH

12. RACE

13. SEX

14. AGE

15. DATE OF BIRTH

16. PLACE OF BIRTH

17. RACE

18. SEX

19. AGE

20. DATE OF BIRTH

21. PLACE OF BIRTH

22. RACE

23. SEX

24. AGE

25. DATE OF BIRTH

26. PLACE OF BIRTH

27. RACE

28. SEX

29. AGE

30. DATE OF BIRTH

31. PLACE OF BIRTH

32. RACE

33. SEX

34. AGE

35. DATE OF BIRTH

36. PLACE OF BIRTH

37. RACE

38. SEX

39. AGE

40. DATE OF BIRTH

41. PLACE OF BIRTH

42. RACE

43. SEX

44. AGE

45. DATE OF BIRTH

46. PLACE OF BIRTH

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69. AGE

70. DATE OF BIRTH

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72. RACE

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74. AGE

75. DATE OF BIRTH

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90. DATE OF BIRTH

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95. DATE OF BIRTH

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97. RACE

98. SEX

99. AGE

100. DATE OF BIRTH

101. PLACE OF BIRTH

102. RACE

103. SEX

104. AGE

105. DATE OF BIRTH

106. PLACE OF BIRTH

107. RACE

108. SEX

109. AGE

110. DATE OF BIRTH

111. PLACE OF BIRTH

112. RACE

113. SEX

114. AGE

115. DATE OF BIRTH

116. PLACE OF BIRTH

117. RACE

118. SEX

119. AGE

120. DATE OF BIRTH

121. PLACE OF BIRTH

122. RACE

123. SEX

124. AGE

125. DATE OF BIRTH

126. PLACE OF BIRTH

127. RACE

128. SEX

129. AGE

130. DATE OF BIRTH

131. PLACE OF BIRTH

132. RACE

133. SEX

134. AGE

135. DATE OF BIRTH

136. PLACE OF BIRTH

137. RACE

138. SEX

139. AGE

140. DATE OF BIRTH

141. PLACE OF BIRTH

142. RACE

143. SEX

144. AGE

145. DATE OF BIRTH

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147. RACE

148. SEX

149. AGE

150. DATE OF BIRTH

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152. RACE

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156. PLACE OF BIRTH

157. RACE

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159. AGE

160. DATE OF BIRTH

161. PLACE OF BIRTH

162. RACE

163. SEX

164. AGE

165. DATE OF BIRTH

166. PLACE OF BIRTH

167. RACE

168. SEX

169. AGE

170. DATE OF BIRTH

171. PLACE OF BIRTH

172. RACE

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174. AGE

175. DATE OF BIRTH

176. PLACE OF BIRTH

177. RACE

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179. AGE

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209. AGE

210. DATE OF BIRTH

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212. RACE

213. SEX

214. AGE

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217. RACE

218. SEX

219. AGE

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222. RACE

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224. AGE

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271. PLACE OF BIRTH

272. RACE

273. SEX

274. AGE

275. DATE OF BIRTH

276. PLACE OF BIRTH

277. RACE

278. SEX

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5225

## CERTIFICATE OF DEATH

05268

Reg. Dist. No. 21

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY OR TOWN <u>Annapolis</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY OR TOWN <u>Annapolis</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3 Carver Street</u>				STREET ADDRESS <u>3 Carver Street</u> (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>McCLAIN</u> (Middle) <u>(Mack)</u> (Last) <u>SIMMS</u>				(Month) <u>6</u> (Day) <u>12</u> (Year) <u>55</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>Colored</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Married</u>	<b>8. DATE OF BIRTH</b> <u>July 5, 1881</u>		<b>9. AGE last birthday</b> <u>66</u> - yrs.		<b>IF UNDER 1 YEAR</b> Months _____ Days _____ <b>IF UNDER 24 HRS.</b> Hours _____ Min. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>West River A.A.Co. Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> _____	
<b>13. FATHER'S NAME</b> <u>William Simms</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Alice Brown</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) _____		<b>16. SOCIAL SECURITY NO.</b> <u>212-10-2820</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Georgiana Simms-3 Carver St. -Annapolis</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>4221 IMMEDIATE CAUSE (A)</b> <u>Uremia</u>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>June 9, 1955</u>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>Arteriosclerotic Cardiovascular disease</u>				<u>1 yr</u>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b> <u>Poly arthritis</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <u>6/15/55</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) _____ (County) _____ (State) _____			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) _____ M. _____		<b>21e. INJURY OCCURRED</b> White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>June 12, 1955</u> <b>to</b> <u>June 12, 1955</u> <b>that I last saw the deceased</b> <u>alive on</u> <u>June 12, 1955</u> <b>and that death occurred at</b> <u>5:10 PM</u> <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>[Signature]</u>				<b>ADDRESS</b> (Street, city, town, state) <u>110 Clay St Annapolis, Md.</u>			
<b>DATE</b> <u>June 15, 1955</u>				<b>DATE SIGNED</b> <u>6/14/55</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>6/15/1955</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Brewer Hill Cemetery</u>		<b>LOCATION (City, town, or county)</b> <u>West St. - Annapolis, Md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Ethel L. Hicks</u>		<b>ADDRESS</b> <u>45 Northwest St. -Annapolis Md.</u>	

RECEIVED  
 JUN 15 1955  
 BUREAU V. S.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

6395

1. DATE OF DEATH

2. PLACE OF DEATH

3. TIME OF DEATH

4. NAME OF DECEASED

5. SEX

6. AGE

7. OCCUPATION

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF DECEASED

14. SIGNATURE OF BURIAL

15. SIGNATURE OF CREMATION

16. SIGNATURE OF OTHER

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **4 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Items 5,6, Film 183 6-28-55 et

5264

## CERTIFICATE OF DEATH

05269

Reg. Dist. No. 26

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Ann Arundle</u>		STATE <u>Md.</u>		COUNTY <u>A.A.</u>			
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL end give nearest town)			
<u>X</u> TOWN <u>Churchton</u>		<u>Fifteen</u>		TOWN <u>Churchton</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
100				1			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Sellman</u> (First) <u>Stewart</u> (Middle) (Last)				<u>June 10</u> 19 <u>55</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>Male</u>		<u>Colored</u>		<u>married</u>		<u>Mar. 11 1893</u>	
						9. AGE last birthday	
						<u>62</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Oysterman</u>		<u>Sea food</u>		<u>Churchton Md.</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Daniel Stewart</u>				<u>Mary F. Fross</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>Yes</u> <u>WW I</u>				<u>—</u>		<u>Dorrine Stewart, Churchton Md.</u>	
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion with Myocardial Infarct</u>						<u>Imm.</u>	
ANTECEDENT CAUSE(S) DUE TO <u>History of heart disease for three</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>years</u>							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>never seen alive</u> , that I last saw the deceased alive on <u>June 10, 1955</u> , and that death occurred at <u>4:20 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Hendrichs</u>				ADDRESS (Street, city, town, state) <u>West River Med Center, Shady Side, Md.</u>			
DATE SIGNED <u>6/10/55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6/14/55</u>		<u>Franklin</u>		<u>Churchton Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		<u>D. B. Bent</u>		<u>Benned Hendrichs</u>			
DATE <u>June 16-55</u>							

# CERTIFICATE OF DEATH

1955

1. NAME OF DECEASED

*William*

*William*

2. DATE OF DEATH

*June 10*

*June 10*

3. PLACE OF DEATH

*Home*

*Charles*

*Stewart*

*Stewart*

4. SIGNATURE OF DECEASED

*Stewart*

BUREAU V. 3

JUN 20 1955

RECEIVED

*Charles*

*Stewart*

*Stewart*

*Stewart*

*Stewart*

*Stewart*

1

## INSTRUCTIONS

1

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05270

5265

## CERTIFICATE OF DEATH

Reg. Dist. No. 20

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <i>cc</i>	MARYLAND	STATE <i>Washington</i>	COUNTY <i>D.C.</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>x Sollewilde, Shadyside 2 days</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <i>47X-3</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00</i>		STREET ADDRESS (If rural give location) <i>5007 13th St N.E.</i>	
<b>3. NAME OF DECEASED</b> (Type or Print) <i>Kenneth Francis Swann JR</i>		<b>4. DATE OF DEATH</b> (Month) <i>June</i> (Day) <i>3</i> (Year) <i>1955</i>	
5. SEX <i>m</i>	6. COLOR OR RACE <i>w</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <i>July 15 1953</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <i>1</i> yrs. IF UNDER 1 YEAR Months Days Hours Min.
11a. BIRTHPLACE (State or foreign country) <i>Washington D.C.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Kenneth Francis Swann SR</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth M. Finnegan</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <i>Kenneth F. Swann SR.</i>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>		<b>18. MEDICAL CERTIFICATION</b>	
929.9 IMMEDIATE CAUSE (A) <i>Drowning, Accidental</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 minutes</i>	
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>52</i> to <i>3 June</i> 19 <i>55</i> , that I last saw the deceased alive on <i>3 June</i> 19 <i>55</i> , and that death occurred at <i>7:40 P.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>F. D. Hendricks</i>		DATE SIGNED <i>June 3 1955</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i>		24. REC'D BY REGISTRAR <i>John W. Williams</i>	
DATE <i>6-3-55</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Bernard H. ...</i>	

# CERTIFICATE OF DEATH

Reg. Dist. No.

IN WITNESS WHEREOF, I have hereunto set my hand and the seal of the Department of Health, at Baltimore, Maryland, this \_\_\_\_\_ day of \_\_\_\_\_, 1955.

DEPARTMENT OF HEALTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

SEX

AGE

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY INTO COUNTRY

DATE OF DEPARTURE FROM COUNTRY

DATE OF RETURN TO COUNTRY

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

BUREAU V. S.

JUN 6 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5266 Item 9, Film G183, 6/30/55 fcy  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05271  
 Reg. Dist.

No. 20

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>aa</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>aa</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>Lothian</i>		LENGTH OF STAY (in this place) <i>2 years</i>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <i>Lothian</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) <i>1</i>			
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First) <i>Samuel Eugene</i>		(Middle) <i>TASKER</i>		(Last) <i>TASKER</i>		(Year) <i>1955</i>	
5. SEX: <i>M</i>		6. COLOR OR RACE: <i>Caucasian</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Single</i>		8. DATE OF BIRTH: <i>5/6/31</i>	
9. AGE last birthday: <i>43</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>Farm hand Tobacco</i>		11. BIRTHPLACE (State or foreign country): <i>Sadler Ky</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <i>Arthur Tasker</i>				14. MOTHER'S M maiden name: <i>Carrie Louise Powers</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>yes</i>		16. SOCIAL SECURITY No.: <i>217-30-3636</i>		17. INFORMANT & ADDRESS: <i>Virginia Owens Lothian Md</i>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				Interval: <i>Sudden</i>			
Immediate cause (a) <i>Drowning</i>							
DUE TO							
Antecedent cause(s) (b)							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <i>8/20/55</i>				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) <i>AAAC 02 MS.</i>		(State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <i>John Hardt</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>6/2/55</i>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>		DATE THEREOF: <i>6/20/55</i>		NAME OF CEMETERY OR CREMATORY: <i>Chews</i>		LOCATION (City, town, or county) (State): <i>Omerville Md</i>	
DATE RECD BY LOCAL REG. <i>8/19/55</i>		REGISTRAR'S SIGNATURE: <i>John W. Williams</i>		24. FUNERAL DIRECTOR: <i>Bernard Hardisty</i>		ADDRESS: <i>Salisbury Md</i>	

1.370

5008

RECEIVED  
JUN 27 1955  
BUREAU V. S.

BUREAU V. S.

JUN 27 1955

RECEIVED



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 14 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5267

## CERTIFICATE OF DEATH

05272

Reg. Dist. No. 20

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>A.A. Co</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>A.A. Co.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Millersville</u>				TOWN <u>MILLERSVILLE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
13. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>STEVEN</u> (Middle) <u>THOMAS</u> (Last)				(Month) <u>6</u> (Day) <u>2</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>MALE</u>	<u>Colored</u>	<u>W</u>	<u>12-27-1873</u>	<u>81</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>FARMING</u>		<u>None</u>		<u>CALVERT Co.</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>?</u>				<u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>unk</u>		<u>218-12-9031A</u>		<u>JAMES THOMAS, Millersville, Md</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A)				INTERVAL BETWEEN ONSET AND DEATH			
<u>162x</u>				<u>1 year</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<u>Arterio sclerosis</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<u>0</u>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb 18, 1955</u> to <u>June 2, 1955</u> , that I last saw the deceased alive on <u>June 2, 1955</u> , and that death occurred at <u>9:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE		M.D.		ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Robert H. [Signature]</u>		<u>110-14th St. [Signature]</u>		<u>6/4/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>6-5-55</u>		<u>John Wesley Church</u>		<u>WATER BURY, Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>June 7, 1955</u>		<u>L. M. Joyce</u>		<u>William Reese</u>		<u>108 N. Wash. St. ANNAPOLIS, Md</u>	

CERTIFICATE OF DEATH

00833

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

BUREAU V. S.

JUN 7 1955

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05273

5268

## CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Crownsville</u>		LENGTH OF STAY (in this place) <u>lyr. 1 mos.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Elkridge</u>		<u>13X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10 Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>Race Point Road</u> ✓			
3. NAME OF DECEASED (Type or Print) (First) <u>Lucy</u> (Middle) <u>Toogood</u> (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>6</u> <u>6</u> 19 <u>55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Aug. 1, 1882</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - -</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Charles Brown</u>				14. MOTHER'S MAIDEN NAME <u>Matilda Waters</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
450.0 IMMEDIATE CAUSE (A) <u>Generalized Arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Known to us since adm. 7/3/53</u>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>- - -</u>							
(C) <u>- - -</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>2</u>		19b. MAJOR FINDINGS OF OPERATION <u>- - - - -</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.) <u>- - - - -</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>- - - - -</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>- - - - -</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>- - - - -</u>			
22. I hereby certify that I attended the deceased from <u>7/3</u> , 19 <u>53</u> , to <u>6/6</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6/6</u> , 19 <u>55</u> , and that death occurred at <u>5:00p.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u> M. D.				ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>			
DATE SIGNED <u>6/6/55</u>							
23. BURIAL INFORMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/9/1955</u>		NAME OF CEMETERY OR CREMATORY <u>Elkridge Cem.</u>		LOCATION (City, town, or county) (State) <u>Elkridge Md.</u>	
24. REC'D BY REGISTRAR <u>June 8, 1955</u>		REGISTRAR'S SIGNATURE <u>Nathaniel M. Joyce</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Kate R. Williams</u>		ADDRESS <u>322 N. Schrock St</u>	

05873

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

# CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
JAMES H. WATSON		Male		45		Jan 15 1890		Baltimore, Md.		Clerk		Heart Disease		Natural	
RESIDENCE		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF DECEASED	
1234 Main St.		Jan 20 1935		10:30 AM		Baltimore, Md.		Clerk		Heart Disease		Natural		JAMES H. WATSON	
FATHER		MOTHER		SPOUSE		CHILDREN		BROTHERS		SISTERS		GRANDCHILDREN		OTHER RELATIVES	
JAMES H. WATSON		MARY H. WATSON		JANE H. WATSON		JOHN H. WATSON		EDWARD H. WATSON		ELIZABETH H. WATSON		CHARLES H. WATSON		MARGARET H. WATSON	

BUREAU V. S.

JUN 9 1935

RECEIVED

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED OUT AND THAT IT IS SIGNED BY THE DECEASED OR HIS NEAREST RELATIVE. IT IS ALSO THE DUTY OF THE REGISTRAR TO SEE THAT IT IS FILED IN THE APPROPRIATE PLACE AND THAT IT IS AVAILABLE FOR THE PUBLIC TO VIEW. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS NOT USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED OUT AND THAT IT IS SIGNED BY THE DECEASED OR HIS NEAREST RELATIVE. IT IS ALSO THE DUTY OF THE REGISTRAR TO SEE THAT IT IS FILED IN THE APPROPRIATE PLACE AND THAT IT IS AVAILABLE FOR THE PUBLIC TO VIEW. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS NOT USED FOR ANY OTHER PURPOSE.

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05274

5269

## CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Port G. G. Meade</u>		LENGTH OF STAY (in this place) <u>2 Years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>		TOWN <u>Severn</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u>				STREET ADDRESS (If rural give location) <u>Rt. 2, Box 42</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>Stanley</u> (Middle) <u>Lee</u> (Last) <u>WALKER, JR.</u>				4. DATE OF DEATH (Month) <u>June</u> (Day) <u>21</u> (Year) <u>19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>June 21, 1955</u>	9. AGE last birthday yrs. <u>6</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>15</u>		IF UNDER 24 HRS. Hours <u>6</u> Min. <u>15</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Stanley Lee Walker</u>				14. MOTHER'S MAIDEN NAME <u>Joanne Catherine Schueler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Stanley Lee Walker, father. Rt. 2, Box 42, Severn, Maryland</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				6 hrs			
IMMEDIATE CAUSE (A) <u>Asphyxia</u>				6 hrs			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Prematurity</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>21 June, 1955</u> to <u>21 June, 1955</u> , that I last saw the deceased alive on <u>21 June, 1955</u> , and that death occurred at <u>1235 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>HERBERT L. NEEDLEMAN</u> M.D.				ADDRESS (Street, city, town, state) <u>U. S. Army Hospital, Ft. G. G. Meade, Maryland</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>22 June 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Post Cemetery</u>		LOCATION (City, town, or county) (State) <u>Fort G. G. Meade, Md.</u>	
24. REC'D BY REGISTRAR <u>WILLIAM L. SAYLOR, 1ST LT USC</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Father Smith, Chaplain, Ft. G. G. Meade, Md.</u>		ADDRESS			

2065182292

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M







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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5270

## CERTIFICATE OF DEATH

05275

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		LENGTH OF STAY (in this place) <u>35 yrs. 3 mos.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		<u>09/13-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>		STREET ADDRESS (If rural give location) <u>328 High Street</u>					
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Isaac</u> (First) <u>Waters</u> (Last)				<b>4. DATE OF DEATH</b> (Month) <u>6</u> (Day) <u>3</u> (Year) <u>19 55</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>Negro</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Married</u>	<b>8. DATE OF BIRTH</b> <u>Unknown</u>	<b>9. AGE last birthday</b> <u>63?</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Oyster Shucker</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Unk.</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S.</u>	
<b>13. FATHER'S NAME</b> <u>William Waters</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Laura Waters</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>Unk.</u> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>Unk.</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Hospital Records</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>IMMEDIATE CAUSE (A)</b> <u>Myocardial insufficiency</u>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>1 year</u>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>advanced pulmonary tuberculosis</u>				<u>5 years</u>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b> <u>psychosis - schizophrenia</u>				<u>35 years</u>			
<b>19a. DATE OF OPERATION</b> <u>  </u>				<b>19b. MAJOR FINDINGS OF OPERATION</b> <u>  </u>			
<b>20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/> <input type="checkbox"/>		<b>21b. PLACE</b> (Home, farm, factory, of INJURY street, office bldg., etc.) <u>  </u>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State) <u>  </u>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Minute) <u>  </u> M. <u>  </u>		<b>21a. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b> <u>  </u>			
<b>22. I hereby certify that I attended the deceased from</b> <u>1/5</u> , 19 <u>55</u> , <b>to</b> <u>6/3</u> , 19 <u>55</u> , <b>that I last saw the deceased alive on</b> <u>6/2</u> , 19 <u>55</u> , <b>and that death occurred at</b> <u>3:10a</u> M., <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Allegard Head Reinmann</u> M.D.				<b>DATE SIGNED</b> <u>6/3/55</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Removal - Burial</u>		<b>DATE THEREOF</b> <u>6/6/1955</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Waugh Cemetery</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Cambridge, Maryland</u>	
<b>24. REC'D BY REGISTRAR</b> <u>June 7, 1955</u>		<b>REGISTRAR'S SIGNATURE</b> <u>N. M. Joyce</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Herbert M. St. Clair, Jr.</u>		<b>ADDRESS</b> <u>Cambridge, Md.</u>	

# CERTIFICATE OF DEATH

2370

Reg. Dist. No.

1. FULL NAME OF DECEASED

2. PLACE OF DEATH

3. SEX AND AGE AT DEATH

4. MARRIAGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. PLACE OF BIRTH

9. TIME OF DEATH

10. PLACE OF DEATH

11. PLACE OF DEATH

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13. AGE

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5226

## CERTIFICATE OF DEATH

05276

Reg. Dist. No. 21

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>ANNE ARUNDEL</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>A.A.Co</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>10 ANNAPOLIS</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		10	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00 805 West St</u>				STREET ADDRESS (If rural give location) <u>805 West St</u>		1	
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>ISABEL</u>		(Middle) <u>G</u>		(Last) <u>WILLIAMS</u>		(Date) (Month) (Day) (Year) <u>6 25 1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>3/10/1868</u>	9. AGE last birthday <u>87</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HARRY E. GUYER</u>				14. MOTHER'S MAIDEN NAME <u>JANE BIRMINGTON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>MRS HABEL W. LATHAM #2</u>	
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.0 IMMEDIATE CAUSE (A) <u>arteriosclerotic heart disease</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>gen. arteriosclerosis</u>						6 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hypertension</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8-25</u> , 19 <u>55</u> , to <u>6-25</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6-21</u> , 19 <u>55</u> , and that death occurred at <u>12:30</u> P.M. from the causes and on the date stated above. <u>6-25-55</u>							
SIGNATURE <u>South Riddle</u>		M.D. <u>45 Franklin St. Annapolis, Md</u>		ADDRESS (Street, city, town, state)		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>6/27/55</u>		NAME OF CEMETERY OR CREMATORY <u>LAWVIEW</u>		LOCATION (City, town, or county) (State) <u>ROCKLEDGE PA.</u>	
24. REC'D BY REGISTRAR <u>JO - O. Ormick</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN M. Taylor &amp; Sons</u>		ADDRESS <u>ANNAPOLIS MD</u>	
DATE <u>June 27, 1955</u>							

# CERTIFICATE OF DEATH

1. NAME OF DECEASED (Print or Write)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. TIME OF DEATH

10. PLACE OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF FUNERAL HOME

16. SIGNATURE OF BURIAL SOCIETY

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5271

## CERTIFICATE OF DEATH

05278

Reg. Dist. No. 13

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>North Linthicum</u>		LENGTH OF STAY (in this place) <u>21 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Vienna</u>		<u>09X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>20 Charles Road</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>RUTH</u> (First) <u>CRAFT</u> (Middle) <u>WRIGHT</u> (Last)				<b>4. DATE OF DEATH</b> <u>June 29,</u> 19 <u>55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>November 4, 1878</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Vienna, Dorchester Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William S. Craft</u>				14. MOTHER'S MAIDEN NAME <u>Roberta Wainwright</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>William E. Wright, Vienna, Maryland</u>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>154X</u> IMMEDIATE CAUSE (A) <u>gen. carcinomatosis,</u>						<u>2 mos.</u>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <u>Carcinoma of rectum</u>						<u>2 yrs.</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C)							
19a. DATE OF OPERATION <u>June 1, 55</u>		19b. MAJOR FINDINGS OF OPERATION <u>Ca or rectum c metastasis</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>  </u> <u>  </u> <u>  </u> <u>  </u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 15,</u> 19 <u>55</u> , to <u>June 29,</u> 19 <u>55</u> , that I last saw the deceased alive on <u>June 28,</u> 19 <u>55</u> , and that death occurred at <u>4:25 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>S. Bonnick</u>		M.D.		ADDRESS (Street, city, town, state) <u>Amos Garrett Blvd., Annapolis, Md.</u>		DATE SIGNED <u>6/29/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 1, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Odd Fellows Cemetery</u>		LOCATION (City, town, or county) (State) <u>Seaford, Delaware</u>	
24. REC'D BY REGISTRAR <u>July 5, 1955</u>		REGISTRAR'S SIGNATURE <u>Caldwell W. Workuff</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Frampton and Son,</u>		ADDRESS <u>Federalsburg, Md.</u>	



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